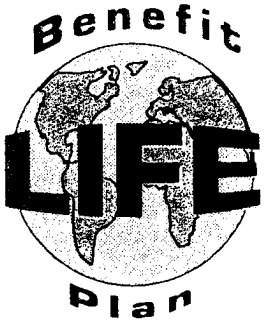


John N. Mongello
Administrator

April 9, 2007

Dear Member:

We wish to clarify the reason that your United Health Care Plan was cancelled.

On or about the beginning of January 2007, we were notified that United Health Care was going to renew the health plan at an additional cost.

As in the past, United Health Care Plan would request that we send out copies of each member's 1099 forms in order to renew. We would contact Pam of Warren Rosen's office and within a two week period, she would, in turn, supply us with the 1099s.

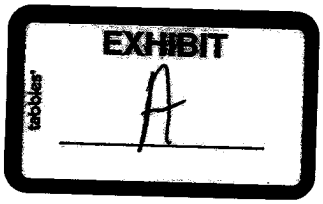
We have telephoned, sent correspondence, and emailed Sabrina at Mr. Rosen's office, on numerous occasions for a period of almost two months, however, to date she has not submitted the 1099s required for renewal.

Therefore, we notified Warren Rosen's office about the cancellation.

We are also notifying United Health Care, as to submitting each member with HIPPA certificates, in order for them to obtain another carrier.

Very truly yours,

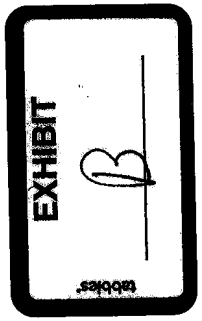
John N. Mongello
Administrator



325 73rd Street Brooklyn, NY 11209 718.238.2399/3994 fax 718.680.0842
Toll Free 1. 866.823.5433 www.lifeunion.com

Warren Rosen & Co.
601 West 26th Street
Suite 1515
New York NY 10001
Phone. 212 949 9200
Fax 212 406 4575

April 9, 2007



Dear Member:

As you may already know your Health Insurance with United Healthcare has been terminated as of 04/01. While we are continuing to pursue Life Benefits and United Healthcare we wanted to make sure you were protected and have coverage as of 04/01.

Warren was able to negotiate with another carrier. (Per4mance Health Plan) that would accept the group and go retro as of 04/01. This is a catastrophic plan and coverage is guaranteed. Per4mance Health Plan is underwritten by Perfect Health insurance company in New York, their international network Multiplan (www.multiplan.com—PPO network) Currently this option is our only option, please be assured that going forward, we will continue to negotiate alternative plan designs and rates with this company.

Attached, you will find a rate sheet with a summary of benefits for the plan option along with applications to enroll in the plan. If you elect to enroll in the plan we will need the attached enrollment forms completed and returned to us along with a copy of your Schedule C or W2 form (This is for the sole purpose of proof of self employment), no later than Thursday. We will also need binder check for the first month premium. Check should be payable to AFID.

Please call our office with any questions.

Sincerely,

Sabrina Ali

E. R. KRAJEWSKI, INC.
256 KENILWORTH AVE
KENILWORTH, IL 60043

2310
2-525/710

DATE April 11, 2007

PAY TO THE ORDER OF AFID $ 830.07

Eight Hundred Thirty and 07/100 DOLLARS

Security Features Details on Back

BURLING BANK
THE BOARD OF TRADE BUILDING
141 WEST JACKSON BOULEVARD CHICAGO, ILLINOIS 60604
312.408.8400

FOR Medical Insurance

E R Krajewski

⑈002310⑈ ⑆071005254⑆ 602008⑈

EXHIBIT 7

PerfectHealth™
Insurance Company

THE PERFECTHEALTH INSURANCE COMPANY
(formerly Anthem Health & Life Insurance Company of New York)
Staten Island, New York 10314

CHANGE OF NAME RIDER

This Rider attaches to and forms a part of the policy, or booklet-certificate issued to you by Anthem Health & Life Insurance Company of New York.

Anthem Health & Life Insurance Company of New York has changed its name to The PerfectHealth Insurance Company. Wherever in said policy, or booklet-certificate the name Anthem Health & Life Insurance Company of New York is stated, the name The PerfectHealth Insurance Company is substituted.

Only the name of the Company has changed. Nothing contained in this Rider changes any of the terms and conditions of the policy, or booklet-certificate.

In Witness Whereof, the Company has signed this Rider as of September 24, 2003.

President

NAMCH (09-03)

EXHIBIT
D

GROUP INSURANCE CERTIFICATE

ANTHEM HEALTH & LIFE INSURANCE COMPANY OF NEW YORK certifies that the person named in the Certificate of Coverage is insured for the insurance described in this booklet, subject to the terms of the Group Policy.

Section 2 of this booklet describes who is eligible and when insurance under a Coverage starts.

This booklet is not your Certificate unless the Certificate of Coverage is attached to the front cover. With your Certificate of Coverage attached, this booklet becomes your Certificate of Insurance.

This Certificate is governed by the terms of the Group Policy. It replaces all previous Certificates issued to you by Anthem Health & Life Insurance Company of New York for insurance under any Coverage described in this Certificate.

ANTHEM HEALTH & LIFE INSURANCE COMPANY OF NEW YORK

EMPLOYEE SECURITY PROGRAM
CERTIFICATE OF COVERAGE

WE CERTIFY THAT WE HAVE INSURED CERTAIN PERSONS AS OF THE EFFECTIVE DATE AND FOR THE INSURANCE SHOWN IN THE INSURANCE SCHEDULE BELOW UNDER:

Group Policy: ESP 1-N — Employer Plan No.: **595246**
Employee: **EDWARD KRAJEWSKI**
Name of Employer: **REAL BENEFITS ASSOCIATION (RBA)**
Issue Date of Certificate of Coverage: **04/01/07** — Booklet No.: GRC-1000

This Insurance Certificate replaces any Certificate previously issued to you by us under the Employer Plan number shown above.

INSURANCE SCHEDULE

Effective Date of this Schedule: **04/01/07**

Kinds of Insurance		Provided	Amount
Major Medical	Employee	Yes	See Below
	Spouse	Yes	
	Children	Yes	

INSURANCE AMOUNTS AND MAXIMUM BENEFITS

Major Medical Insurance

Copayment Percent	
PPO Services	80%
Non-PPO Services	70%
Yearly Deductible	
PPO and/or Non-PPO Services	
Single Coverage	$ 10,000
Family Coverage	$ 20,000
Yearly Copayment Limit	
PPO Services	$ 10,000
Non-PPO Services	$ 10,000
Maximum Benefit	$2,000,000

Under certain circumstances the amount of expenses that will be considered Covered Expenses will be reduced. Refer to the **Major Medical Insurance Coverage** Section for details.

Anthem Health & Life Insurance Company of New York

REQUIRED DISCLOSURE STATEMENT

The insurance evidenced by this Certificate provides those Coverages indicated on your Certificate of Coverage. It does NOT provide basic hospital or basic medical insurance.

Section 1 of this Certificate is a synopsis of your benefits under the Group Policy. This Certificate also includes exclusions and limitations which apply to those benefits. Such a synopsis is required by the New York State Insurance Department.

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SOME PROVISIONS OF THE POLICY OF INTEREST TO YOU

This "coverage at a glance" is a general overview. The Plan described in this booklet is provided by a Group Policy issued by Anthem Health & Life Insurance Company of New York. The Coverages, benefits and amounts described and all other provisions are subject to the Group Policy. They may be changed at a later date. Any change in your or your dependent's insurance, class or status will take effect only when all of the Policy terms have been met.

PLAN EFFECTIVE DATE

The Plan Effective Date is Shown in your Certificate of Coverage.
This booklet describes the coverage available under the Plan.

COVERAGES AVAILABLE TO YOU

See your Certificate of Coverage.

COVERAGES AVAILABLE TO YOUR DEPENDENTS

See your Certificate of Coverage.

INSURANCE AMOUNTS AND MAXIMUM BENEFITS

Major Medical Insurance
See your Certificate of Coverage.

GROUP COVERAGE AT A GLANCE

SOME TERMS YOU SHOULD KNOW

You and **your** mean you, the employee.

We, us and **our** mean Anthem Health & Life Insurance Company of New York **(Anthem Health of New York)**.

Insured means you or a dependent of yours while insured under this Plan.

Family Unit means you and your insured dependents.

A **Participating Employer** or **Employer** is an Employer who subscribes to the Employee Security Program Trust and who qualifies for participation in the Industry Trust Fund under the Trust.

A **year** is a calendar year running from January 1 through December 31.

Medicare means the benefits of Title XVIII of the Social Security Act of 1965, and all amendments to it.

Active, full-time work means doing the normal duties of your job at least 30 hours a week on a regular basis. This does not include time you work at home or while confined in a Hospital or similar place.

Medical Expense Coverage means Major Medical Insurance Coverage.

Late Enrollee means an eligible person for whom you apply for insurance under this Plan more than 31 days after the person's eligibility date. But, the person will not be considered a "late enrollee" for Medical Expense Coverage if:

1. Each of the following conditions are met:

   a. The person was covered under Qualifying Previous Coverage when he or she first became eligible for this Plan; and

   b. He or she lost that coverage because of:

      - involuntary termination of the Qualifying Previous Coverage; or

      - death of a spouse or divorce; and

   c. You apply for that person's insurance under this Plan within 31 days after termination of the Qualifying Previous Coverage; or

2. Your employer offers more than one health benefit plan, and you elect coverage under a different plan during an open enrollment period; or

3. A court has ordered coverage for your spouse or minor or dependent child under this Plan, and you apply for coverage within 31 days after issuance of the court order.

Qualifying Previous Coverage means benefits or coverage provided under:

- an employer based benefit plan.

  This includes self-insured plans under the federal Employee Retirement Income Security Act of 1974, as amended.

- a health benefit plan or arrangement.

GROUP COVERAGE AT A GLANCE

SOME PROVISIONS OF THE POLICY OF INTEREST TO YOU

ENTIRE CONTRACT

The entire contract consists of: 1) the Policy; and 2) the application of the Policyholder (a copy of which is attached); and 3) the written statements of the insureds and of the Participating Employers (as approved by us) which apply to the Employers' Benefit Plans.

All statements made by the Policyholder or by the Participating Employers or by the insureds will be deemed to be representations and not warranties. No statement made by an insured or by a Participating Employer will be used to avoid insurance, reduce the benefits, or defend a claim under the Policy unless:

1. the statement is in writing and signed by the insured or the Participating Employer, as applicable; and

2. a copy of that statement is or has been given to the insured or to his or her beneficiary or to the Participating Employer, as applicable.

MISSTATEMENT OF AGE

If the age or date of birth of an insured has been misstated, his or her true age will be used to determine: 1) his or her amount of insurance; 2) the date insurance starts or ends; and 3) any other rights or benefits under the Policy. Premiums will be adjusted so that we will receive the correct premiums for the true age.

POLICY CHANGES

We may change the Policy at any time. But the change must be approved by one of our executive officers. We will not be bound by a promise or representation made by any other person. No agent has the authority to change the Policy in any way or to waive any of its terms.

INCONTESTABILITY WITH RESPECT TO AN EMPLOYER'S BENEFIT PLAN

No statement made by a Participating Employer or by an insured relating to eligibility or insurability under the Policy will be used in contesting the validity of that Employer's Benefit Plan after that Plan has been in force under the Policy for 2 years prior to the contest or unless:

1. the statement is in writing and signed by the Employer or by the insured; and

2. a copy of that statement is or has been given to the Employer.

INCONTESTABILITY WITH RESPECT TO INSURED PERSONS

No statement made by any person insured under the Policy relating to his or her insurability (proof of good health) will be used in contesting the validity of the insurance with respect to which that statement was made unless:

1. the statement is in writing and signed by that person; and

2. a copy of that statement is or has been given to that person or to his or her beneficiary.

CLERICAL ERROR

A clerical error on the part of the Policyholder or a Participating Employer or us will not:

1. deprive a person of the insurance he or she is entitled to under the Policy; nor
2. cause insurance to continue beyond the date on which it would reduce or end.

If such an error is discovered, a fair adjustment of premiums will be made.

However, none of the following will be considered to be a clerical error:

- we do not receive an application for insurance to take effect or increase; or
- we are not notified of a change in an insured's benefit class which would otherwise have qualified that person for an increase in benefits under the Employer's Benefit Plan.

Coverage in such circumstances shall extend only to that which we have approved in accordance with the provisions of the Policy.

A SUMMARY

This Section is a very brief summary of the Coverages and benefits available to you under the Group Policy.

The Policy sets forth the rights and obligations of both the Policyholder and us.

Each Coverage is described in detail on the pages which follow. Those pages list the losses and expenses we do not cover under each Coverage. Here is a synopsis of some of these common exclusions and limitations:

-- The Coverages which provide benefits for health care expenses do not cover expenses:

- for Medical Care not recommended and approved by a doctor;
- for care received in facilities owned or run by or furnished at the expense of the U.S. Government or one of its agencies;
- for care for which the insured - without this insurance - would not legally be obligated to pay;
- for occupational injury or sickness.

THIS CERTIFICATE CONTAINS OTHER EXCLUSIONS AND LIMITATIONS WHICH ARE NOT LISTED ABOVE. THE FULL TEXT OF THE EXCLUSIONS AND LIMITATIONS WHICH APPLY TO EACH COVERAGE CAN BE FOUND ON THE PAGES WHICH FOLLOW WHICH DESCRIBE THAT COVERAGE IN DETAIL.

Also, Policies often have special limits for mental illness, private duty nursing, and out-patient care, as well as special provisions which apply to persons who are eligible for Medicare.

This Certificate describes your insurance provided under the Policy. Thus it is important that you READ YOUR CERTIFICATE carefully.

SECTION 2

HOW TO BECOME INSURED

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HOW TO APPLY

WHEN YOUR INSURANCE STARTS

CHANGES IN YOUR INSURANCE

WHO ARE ELIGIBLE DEPENDENTS

WHEN DEPENDENTS BECOME ELIGIBLE

HOW TO APPLY FOR DEPENDENTS INSURANCE

WHEN DEPENDENTS INSURANCE STARTS

CHANGES IN A DEPENDENT'S INSURANCE

WHO IS ELIGIBLE, AND WHEN

You are eligible under this Plan if:

- you are a full-time employee of a Participating Employer; and
- you have completed the service waiting period required by your Employer, if any.

You are eligible on the date you meet these conditions (but not before the Plan Effective Date). This is your eligibility date.

To be a "full-time" employee, you must be on a 30 or more hour work week schedule on a regular basis with your Employer. This does not include time you work at home, or while confined in a Hospital or similar place. Part-time, temporary, or substitute employees are not eligible.

HOW TO APPLY

In order for your insurance under a Coverage to start, you must first apply for it.

To apply, just complete an enrollment form no later than 31 days after your eligibility date and return it to your Employer.

Medical Expense Coverage

If you apply for Medical Expense Coverage within 31 days after your eligibility date, we will not require you to submit proof of your good health.

If you apply for Medical Expense Coverage more than 31 days after your eligibility date, or if you apply for Coverage after canceling it, you may be considered a Late Enrollee (refer to the definition in Section 1).

If you are a Late Enrollee for Medical Expense Coverage, we will require proof of your good health by our standards. This proof must be provided at your own expense.

WHEN YOUR INSURANCE STARTS

Subject to the Special Requirements shown below, your insurance will start on the first day of the month which falls on or next after the latest of these dates:

For Medical Expense Coverage:

a. If you apply within the 31-day enrollment period, your eligibility date.

b. If you apply after the 31-day enrollment period, but you are not considered a Late Enrollee, the date you apply for insurance.

c. If you are a Late Enrollee and we approve your proof of good health, the date of approval.

d. If you are a Late Enrollee and we do not approve your proof of good health, you may be excluded from Medical Expense Coverage for up to 18 months from the date you apply for insurance. In addition, any pre-existing condition exclusion contained in this Plan will apply, but not longer than 18 months from the date you apply for insurance.

The date your insurance under a Coverage starts is shown in the Certificate of Coverage.

But you must be at active, full-time work for your Employer in order for your insurance to start. If you are not, your insurance will start on the date you come back to active, full-time work. ("Active, full-time work" means doing the normal duties of your job. This does not include time you work at home, or while confined in a Hospital or similar place.)

Special Requirements

1. This Special Requirement applies to you if:

   - you must prove that you are in good health in order for your insurance to start; and

   - you cease to be eligible for the insurance before you give that proof.

   In this case, you will still have to provide that proof if you again become eligible and apply for insurance. Your insurance will start on the first day of the month which falls on or next after the date proof of your good health is approved. (You must provide this proof at your own expense.)

CHANGES IN INSURANCE

Any increase in your insurance amounts or coverage will take effect on the latest of these dates:

- the first day of the month which falls on or next after the date we approve your proof of good health, if such proof is required by then current underwriting standards;
- the first day of the month which falls on or next after the effective date of the change;
- the first day of the month which falls on or next after the date you come back to active, full-time work, if you are not at active, full-time work on the date the increase would take effect;
- the first day of the month which falls on or next after the date your Employer reports the change to us, so long as this takes place within 60 days of the effective date of the change. Otherwise, you will continue to be insured for the prior amount until you give us, at your own expense proof of your good health. (In this event, the increase will take effect on the date we approve your proof of good health.)

Any decrease in your insurance amounts or coverage will take effect on the first day of the month which falls on or next after the effective date of the change.

WHO ARE ELIGIBLE DEPENDENTS

Except as stated below, your dependents who may become eligible under this Plan are:

- your spouse;
- your unmarried children under age 19; and
- your unmarried children age 19 but under age 26 who are full-time students at an accredited school or college and fully supported by you. "Full-time student" means full-time as defined by the rules of the school or college.

The term "children" means:

- your natural children;
- your adopted children; and
- any other children who live with you in a parent-child relationship, and are chiefly dependent upon you for support and maintenance.

No person who is eligible as an employee under this Plan may be eligible as a dependent. Also, a person may not be a dependent of more than one employee.

No spouse or child who is on active military duty may be eligible as a dependent.

WHEN DEPENDENTS BECOME ELIGIBLE

A dependent becomes eligible on the latest of these dates (but not before the Plan Effective Date, or the date you are in a class eligible for Dependents Insurance:

- the date he or she becomes a dependent of yours;

- in the case of a newborn child, the date of birth; or

- in the case of a newly adopted child, the date the child is placed with you pending final adoption. Such a child will remain eligible unless the adoption process stops, and the child is removed from placement with you.

This is the dependent's eligibility date.

HOW TO APPLY FOR DEPENDENTS INSURANCE

In order for a Dependents Insurance under a Coverage to start, you must first apply for it.

To apply, just complete an enrollment form no later than 31 days after your dependent's eligibility date and return it to your Employer.

Medical Expense Coverage

If you apply for Medical Expense Coverage within 31 days after your dependent's eligibility date, we will not require you to submit proof of the dependent's good health.

If you apply for Medical Expense Coverage more than 31 days after your dependent's eligibility date; or if you apply for Coverage after canceling it, the dependent may be considered a Late Enrollee (refer to the definition in Section 1).

If your dependent is a Late Enrollee for Medical Expense Coverage, we will require proof of the dependent's good health by our standards. This proof must be provided at your own expense.

Addition of Dependents

Even if you have Dependents Insurance, you still have to apply in order for any new dependent to become insured.

Exception for a Newborn or Newly Adopted Child

Whether or not you already have Dependents Insurance, your newborn child will be insured immediately from the date of birth, unless you decline the insurance in writing. Your adoptive child will be insured immediately from: (a) the date of birth, if you take physical custody of the child upon its release from the hospital, and the petition to adopt is filed within 30 days after birth; or (b) the date he or she is placed with you, if the placement is more than 30 days after birth. You must apply for insurance and pay the required premium, if any, within 31 days after the date of birth or adoptive placement in order for the insurance to continue beyond this 31-day period.

Coverage is provided for treatment of injury, sickness, birth defects and extra medical care needed as a result of premature birth.

Coverage is also provided for these charges made for the routine care of a newborn child received before the child leaves the Hospital in which he or she was born: (a) Hospital nursery charges; (b) charges for routine tests and doctors' examinations; (c) charges for circumcision. But we do not cover any routine care of the child once he or she has left the Hospital, except as described in the Major Medical Insurance Coverage Section.

Exception for Court Order Child Coverage

If you receive a court or administrative order to provide insurance for an eligible child not currently enrolled, you may apply for insurance within 31 days of receipt of the court or administrative order. You must provide us with a copy of the court or administrative order. If you fail to apply as ordered, the child's other parent or legal custodian, or the state's Medicaid agency may apply for the insurance. You may not stop insurance for such a child under this Plan unless you provide us with written evidence that:

1. The court or administrative order is no longer in effect; or

2. The child is enrolled in similar health care coverage; or

3. Your employer has eliminated family health insurance for all employees.

WHEN DEPENDENTS INSURANCE STARTS

Subject to the Special Requirements shown below, your dependent's insurance will start on the first day of the month which falls on or next after the latest of these dates (but not before the date your own insurance which provides similar coverage starts):

1. For Medical Expense Coverage:

   (a) If you apply within the 31-day enrollment period, the dependent's eligibility date.

   (b) If you apply after the 31-day enrollment period, but the dependent is not considered a Late Enrollee, the date you apply for insurance.

   (c) If the dependent is a Late Enrollee and we approve that proof, the date of the approval.

   (d) If the dependent is a Late Enrollee and we do not approve the dependent's proof of good health, he or she may be excluded from Medical Expense Coverage for up to 18 months from the date you apply for insurance. In addition, any pre-existing condition exclusion contained in this Plan will apply, but not longer than 18 months from the date you apply for insurance.

The date a dependent's Insurance under a Coverage starts is shown in the Certificate of Coverage. But a dependent (other than a newborn child or newly adopted child) must not be confined in a Hospital or similar place, or at home in lieu of Hospitalization on the date his or her insurance would take effect in order for his or her insurance to start. If a dependent is confined, his or her insurance will start on the day after the date of his or her final discharge from the facility or home care program.

Special Requirements

1. This Special Requirement applies to a dependent who:

   - must prove that he or she is in good health in order for insurance to start; and

   - ceases to be eligible for the insurance before that proof is given.

   In this case, you will still have to give that proof if the dependent again becomes eligible and applies for insurance. His or her insurance will start on the first day of the month which falls on or next after the date that proof of good health is approved. (You must provide this proof at your own expense.)

CHANGES IN A DEPENDENT'S INSURANCE

Any increase in a dependent's insurance amounts or coverage will take effect on the latest of these dates:

- the first day of the month which falls on or next after the date we approve your dependent's proof of good health, if such proof is required by then current underwriting standards;
- the first day of the month which falls on or next after the effective date of the change;
- the date a similar change in your insurance takes effect;
- in the case of a dependent who is confined in a Hospital or similar place, or at home in lieu of Hospitalization on the date the increase would take effect, the first day of the month which falls on or next after the date of his or her final discharge from the facility or home care program.
- the first day of the month which falls on or next after the date your Employer reports the change to us, so long as this takes place within 60 days of the effective date of the change. Otherwise, the dependent will continue to be insured for the prior amount until you give us, at your own expense, proof that your dependent is in good health. (In this event, the increase will take effect on the date we approve that proof.)

Any decrease in a dependent's insurance amounts or coverage will take effect on the first day of the month which falls on or next after the effective date of the change.

SECTION 3

GENERAL INFORMATION ABOUT YOUR HEALTH CARE COVERAGES

Health care coverage is designed to help you pay for your and your family's health care expenses. Many kinds of expenses you have in connection with hospital, surgical, medical care are covered. Some are not.

The Health Care Coverages provided under this Plan are described in the following Sections. In each of these Sections we tell you which expenses we pay for under that Coverage and how much of each expense we pay. We also tell you which expenses are not covered.

In the **Coordination of Health Care Benefits** Section, we tell you how we pay these benefits when you are entitled to benefits from Medicare, other insurance plans and other sources of payment. Because federal law has many different rules, we may not always coordinate with Medicare. Sometimes Medicare will pay first and we will coordinate with its benefits. At other times, we must pay our benefits before Medicare. And in some cases, even though federal law requires that this Plan pay its benefits before Medicare, the insured has the right to elect to have Medicare be the primary payer of his or her hospital, surgical and medical benefits. If this happens, then he or she will not be insured under this Plan for these benefits. More information about Medicare benefits may be obtained from the nearest Social Security Office.

In the **How To Convert To Individual Insurance** Section, we tell you how and when you may convert to individual medical insurance.

Before we pay any benefits under a Coverage we must receive proof that all requirements of that Coverage have been met. In the **How To File A Claim** Section, we tell you how to make a claim for benefits.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

The Major Medical Insurance Coverage provided under this Plan is a Preferred Provider Organization (PPO) plan. The PPO uses a network of Providers who are carefully selected based on high professional standards; and who have agreed to provide services to insureds at discounted fees. To encourage you to join the effort to control health care costs, you will have less out-of-pocket expenses when you and your family use the services of a PPO Provider.

PPO Providers

Benefits for Covered Expenses incurred for Medical Care rendered by PPO Providers will be paid based on the Negotiated Fees established for those Providers. A Negotiated Fee is the amount that a PPO Provider has agreed to charge for a particular service, treatment, or supply. The fee reflects a discount from the PPO Provider's standard charge, When Medical Care is rendered by a PPO Provider, the PPO Provider will only charge the Negotiated Fee for that Medical Care. You will be responsible for any Copay, Deductibles, and Copayment Percent applicable to the Covered Expense.

Non-PPO Providers

Benefits for Covered Expenses incurred for Medical Care rendered by Non-PPO Providers will be based on the Prevailing Negotiated Fees. A Prevailing Negotiated Fee is the most common or average Negotiated Fee for a particular service, treatment, or supply established in the locale where the Medical Care is rendered. When Medical Care is rendered by a Non-PPO Provider, the maximum charge that will

be considered a Covered Expense will be the Prevailing Negotiated Fee. If a Non-PPO Provider charges an amount greater than the Prevailing Negotiated Fee, you will be responsible for the difference between the Prevailing Negotiated Fee and the amount charged. You will also be responsible for any Deductible and Copayment Percent applicable to the Covered Expense. Any amount in excess of the Prevailing Negotiated Fee will not apply towards any Deductible or Copayment Limit.

In the event that a Negotiated Fee has not been established for a particular Covered Expense, benefits will be based on the reasonable charge for that service, treatment, or supply.

DEFINITIONS

Here are some basic terms that you should know. We use these terms when we describe your health care Coverages.

Doctor means:

1. A duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.); and

2. Any other duly licensed practitioner of the healing arts if:

   (a) we are required by the law of the proper governmental authority to recognize that person; and

   (b) that person provides services which are within the scope of his or her license and which are covered by this Plan.

An expense is **incurred** at the time the medical care is received.

An expense is **reasonable** if:

1. For a PPO Provider, the charge is the negotiated fee; or

2. For a Non-Network Provider, the charge is the Prevailing Negotiated Fee; or

3. In our judgment, the charge is the usual and customary charge for that attention or care in the locale where it is received. If we cannot determine the usual and customary charge for the attention or care because there are not enough providers of that attention or care in the locale to establish a prevailing charge, we will calculate the reasonable charge for it based on:

   - the complexity of the attention or care; and

   - the degree of professional skill needed to provide it; and

   - other pertinent factors.

   The usual and customary charge will also be considered reasonable for:

   - Emergency care provided by a Non-Network Provider;

   - Out-of-Area Dependent Coverage; or

   Medical Care for which a Negotiated Fee or Prevailing Negotiated Fee has not been established.

Medical Care means necessary services, supplies, diagnosis, treatment, drugs and medicines provided for the care or treatment of an injury or a sickness or a pregnancy. A service, supply, diagnosis, treatment, drug or medicine is necessary if it is recognized by the organization which establishes standards for the provider as being appropriate, effective and essential for the care or treatment of the

injury, sickness or pregnancy. But expenses for the following Medical Care will not be considered necessary:

- that provided as an in-patient, if the care or treatment of the injury, sickness or pregnancy could safely and adequately have been provided on an out-patient basis; or
- that provided mainly for the personal comfort or convenience of the insured; or
- that part of the Medical Care for which the cost is more than any other Medical Care which could safely and adequately have treated the injury, sickness or pregnancy; or
- that which is experimental, investigative, developmental or educational in nature, or which is not generally recognized by the organization which establishes standards for the provider as beneficial for the care or treatment of the injury, sickness or pregnancy.

Medical Care is not limited to care or treatment of a sickness or injury. It includes certain routine examinations and preventive screening, as described in the **Major Medical Insurance Coverage** Section.

Psychiatric Care means Medical Care for a mental or nervous disorder.

Injury means a bodily injury caused by an accident.

Sickness means a disorder, a disease or an illness. (Any type of hernia or strained back is considered a sickness rather than an injury.)

All injuries or sicknesses due to the same or a related cause are considered **one injury or sickness**.

Pregnancy is considered a sickness under your health care coverage. This means that it is covered just like a sickness. Pregnancy includes childbirth, abortion, miscarriage and complications arising from pregnancy.

A Complication of Pregnancy means these conditions which are distinct from but caused or affected by a pregnancy and which require treatment before the end of the pregnancy:

- acute nephritis or nephrosis; or
- cardiac decompensation or missed abortion; or
- a similar condition as severe as these.

Not included are: (a) false labor, occasional spotting, or doctor prescribed rest; (b) morning sickness; and (c) similar conditions not medically distinct from a difficult pregnancy.

A Complication of Pregnancy also includes:

- a non-elective Caesarian section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible; and
- hyperemesis gravidarum and pre-eclampsia.

You are **totally disabled** when you are not able to work at all at any job or business for pay or profit due to injury or sickness. A dependent is totally disabled when he or she is not able at all to perform, due to injury or sickness, the normal daily activities of a person of like age and sex.

Year means a calendar year running from January 1 through December 31.

Hospital means a facility which meets all of these tests:

- it provides in-patient services for the care and treatment of injured and sick people; and
- it provides room and board services and graduate nursing services 24 hours a day; and
- it has established facilities for diagnostic x-ray and laboratory examinations and major surgery; and
- it is supervised by a doctor; and
- it is licensed as a Hospital under the laws of the jurisdiction in which it is located.

But a Hospital is not required to have major surgery facilities in the case of a confinement for alcoholism, drug addiction or any mental, nervous or emotional disorder.

A Hospital does not include: (a) a Convalescent Care Facility or similar place even if it is affiliated with a Hospital; (b) a clinic; (c) a nursing or rest home; or (d) a place run mainly for the care of the aged.

In-Patient means an admitted patient of a facility who needs its room and board services.

Out-patient means any patient of a facility who is not an in-patient.

Hospital confinement means time spent in a Hospital:

- as an in-patient, for which a room and board charge is made; or
- as an out-patient, for treatment of an injury within 48 hours after the accident in which the injury occurs; or
- as an out-patient, for surgery or for surgery related treatment within 24 hours before or after that surgery occurs; or
- as an out-patient, for pre-admission tests ordered by the insured's doctor to prepare for surgery scheduled to be done in that Hospital.

A previous confinement and a current one are treated as **one period of confinement** unless:

1. they are due to unrelated causes; or
2. they are separated by at least 90 days; or
3. in your case, they are separated by your return to active, full-time work for at least one full day.

Convalescent Care Facility means a properly licensed facility which meets all of these tests:

- it is mainly engaged in providing in-patient care for people recovering from injury or sickness; and
- it is supervised by a doctor or registered nurse; and

- it provides 24 hour per day nursing services and the emergency services of a doctor; and
- it keeps complete medical records on all patients; and
- it has transfer arrangements with at least one Hospital; and
- it has a utilization review plan and follows policies developed with the advice of a professional group (including at least one doctor) that also reviews those policies from time to time; and
- it requires that each patient be under a doctor's care; and
- it must not be a place mainly for: alcoholics, drug addicts or the mentally ill; tuberculosis or maternity patients; the aged, blind or deaf; or rest or custodial care.

Ambulatory Surgical Center means a properly licensed facility which meets all of these tests:

- it is equipped and operated mainly to perform surgery; and
- it has an organized staff of doctors and continuous medical and registered nursing services whenever a patient is there; and
- it keeps adequate medical records on all patients and has a utilization review plan; and
- it has transfer arrangements with at least one Hospital; and
- it does not provide accommodations for patients to stay overnight.

Hospice means a facility which provides a place to stay for short periods of time in a home-like setting for the insured who has a terminal illness. These stays must be for direct care or rest from the symptoms of the terminal illness.

Hospice Care Services mean services and supplies to: (a) reduce or lessen pain or other symptoms of mental or physical distress; and (b) meet the needs that arise out of the stresses of a terminal illness, dying and bereavement. These services must be provided by a Hospice or a Hospice Team.

Hospice Care Program means a formal program of Hospice Care Services for the insured who has a terminal illness. The Program must:

1. Be written and directed by a doctor;
2. Meet standards set by the National Hospice Organization; and
3. Be certified by the state in which it is in operation.

Hospice Team means a group of professional and volunteer workers. The group must include at least a doctor and a registered nurse (R.N.). It may include: a social worker; a clergyman or counselor; volunteers; a clinical psychologist; a physiotherapist; or an occupational therapist.

Birthing Center means a properly licensed facility which meets all of these tests:

- it is mainly engaged in providing care for childbirth, including prenatal and postpartum care; and
- it provides 24 hour a day nursing service by or under the supervision of registered graduate nurses (R.N.) and certified nurse midwives; and
- it requires that a doctor examine the patient at least once before delivery; and

- it requires only a doctor perform any surgical procedure; and

- it contains at least the following equipment, and has trained personnel to operate that equipment: (a) a fetal monitor; (b) an incubator; and (c) a resuscitator; and

- it does not keep any patient for more than 24 hours of in-patient treatment; and

- it has a written agreement in force with at least one Hospital for immediate transfer of patients who require treatment in a Hospital; and

- it keeps complete medical records on all patients; and

- it has a utilization review plan.

Provider means a person or institution who or which provides care to an insured.

Preferred Provider Organization or **PPO** means the network of health care providers who are members of the Organization shown on your Identification Card. These health care providers have agreed to provide high quality, cost-effective health care.

PPO Provider means a member of the PPO who, at the time of providing services, has a contract with us to provide services to insureds. Refer to your directory for a list of PPO Providers in your area. You may also call the number on your identification card for help in finding a PPO Provider. You should always confirm that a PPO Provider is still contracted with us before services are provided. In the event a PPO Provider's agreement with us terminates, an insured may be required to use another PPO Provider.

Non-PPO Provider means a Provider who does not have a contract with us to provide services to insureds.

Service Area means the geographical area designated in the Provider Directory in which Network Providers are available.

Negotiated fee means the amount that a Network Provider has agreed to charge for Covered Expenses provided to the insured.

Prevailing Negotiated Fee means the most common Negotiated Fee established for a service, treatment, or supply in the locale where it is received, as determined by us.

Emergency Care means the care provided to the insured who suffers an accidental injury or the sudden onset of a medical condition with symptoms so severe, including severe pain, that without immediate medical attention the insured could reasonably expect that:

1. His or her health would be in serious jeopardy;

2. His or her bodily function would be seriously impaired; or

3. A bodily organ or part would be seriously damaged.

SECTION 4

MAJOR MEDICAL INSURANCE COVERAGE

WHAT IS MAJOR MEDICAL INSURANCE?

PREFERRED PROVIDERS ORGANIZATION (PPO) PLAN

THE BENEFITS

EXPENSES THAT WE LIMIT

COVERED EXPENSES

EXPENSES WE DO NOT COVER

WHEN WE EXTEND BENEFITS

Refer to the **General Information About Your Health Care Coverages** Section to see how certain terms used in this Section are defined.

WHAT IS MAJOR MEDICAL INSURANCE?

Under this Coverage, we pay the benefits shown below, if an insured incurs Covered Expenses. These expenses must be incurred while he or she is insured under this Coverage. And they must be incurred as a result of an injury or a sickness or a pregnancy. We will also pay expenses for certain routine examinations and preventive screening, but only as described later on in this Section.

"Covered Expenses" include many kinds of expenses you and your family have in connection with doctor visits and hospital stays. We list them later on in this Section.

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

This Coverage is a Preferred Provider Organization (PPO Plan). This Plan pays benefits based on Negotiated Fees for PPO Providers. **Read the General Information About Your Health Care Coverage Section of this Plan carefully for complete details.**

In addition, there are other advantages to using PPO Providers:

1. **No claims to file.** If a PPO Provider provides the Medical Care, all you have to do is present your Identification Card to the PPO Provider and pay any required Copay. You do not have to file a claim. The PPO Provider will file the claim for you.

2. **Pre-authorization for in-patient confinements.** All in-patient confinements must be authorized in advance, or the amount that we consider the Covered Expense will be reduced by 20%. The reduction will apply to all charges incurred in connection with the confinement. A PPO Provider will automatically obtain the authorizations for you. You are responsible for obtaining the authorization if the service is provided by a Non-Network Provider. You, your doctor or a family member may start the review process. Refer to your Identification Card for instructions.

Freedom of Choice

Under this Plan, you are not required to have your Medical Care provided by a PPO Provider. You and your family have the freedom to choose any Provider at the time of service. However, you will have less out-of-pocket expenses when you and your family use the services of a PPO Provider.

You will be given a directory with the current listing of Providers in the PPO Network at least once a year. However, prior to going to any PPO Provider, we urge you to call the number listed on your Identification Card to determine if:

- a Provider listed in the directory is still participating in the PPO Network; and
- any additional or specialized Providers have recently joined the PPO Network in your area.

If you choose to go to a Non-PPO Provider, we urge you to have that Provider call us to determine what the Prevailing Negotiated Fee is for the Medical you will be receiving.

Pre-Authorization Required

In order to ensure that you and your insured family members are receiving the best care in the most appropriate setting, the following services must be pre-authorized:

- any confinement other than a confinement as a result of Emergency Care;
- a confinement as a result of Emergency Care, if we are not notified of it within 48 hours after it starts (within 72 hours, if it starts between 5:00 P.M. on Friday and 8:00 A.M. on the next Monday); or
- any part of a confinement which lasts longer than the time authorized.

To have these services authorized, follow the instructions on your Identification Card.

Penalty

If a confinement is not pre-authorized, the Covered Expenses for all charges incurred in connection with that confinement will be reduced by 20%. This means that we will not pay any benefits for the amount reduced, and that amount will not apply toward the Deductible or the Copayment Limit.

THE BENEFITS

Except as limited under **Expenses That We Limit**, or excluded under **Expenses We Do Not Cover**, we pay benefits for **Covered Expenses**, subject to all the terms and conditions of this Plan. The benefits payable are subject to the applicable Copays, Deductibles, Copayment Percents, Copayment Limits and the Maximum Benefit as shown in Section 1, **Group Coverage at a Glance**.

The Copay

The Copay is the amount the insured must pay for certain services which are provided by a PPO Provider. The Copays are shown in Section 1, **Group Coverage at a Glance.** These Copays do not apply toward the Deductible or the Copayment Limit.

The Yearly Deductible

The Yearly Deductible is the amount of Covered Expenses that an insured must first incur each year before we pay Major Medical benefits for that year. (We do not pay for these "Deductible" expenses. They must be incurred while insured under this Coverage.

The Deductible can be met with Covered Expenses incurred for PPO Services, for Non-PPO Services or both. We apply expenses to the Deductible in the order they are incurred. If that is not practical, we apply expenses in the order they are claimed.

Deductible Transfer Provision

For any person who was insured under your Employer's Old Plan on the day it ended and who is insured under this Coverage on its effective date, we will apply certain expenses incurred under the Old Plan toward meeting the Deductible of this Coverage. We will do this if those expenses:

- were applied to the deductible of the Old Plan; and
- were incurred on or after October 1 of the year prior to the year in which this Coverage took effect; and
- are Covered Expenses under this Coverage; and
- are subject to a similar deductible requirement under this Coverage.

"Old Plan" means your Employer's prior plan of group insurance which provides benefits similar to the benefits provided by this Coverage.

Family Deductible

The Family Deductible is shown in Section 1, **Group Coverage at a Glance.** When the Family Deductible applies the Per Person Deductible does not apply. The family deductible is an aggregate amount that can be satisfied by one or any combination of family members incurring expenses toward this yearly amount.

The Copayment

The Copayment Percent is the percentage of Covered Expenses that the Plan pays after the Deductible is satisfied.

"Copayment Limit" means the amount of Covered Expenses that the insured must incur each year before the rate we pay becomes 100%. The Copayment Limit is shown in Section 1, **Group Coverage at a Glance.** Once the Yearly Copayment Limit is satisfied, the Copayment Percent will increase to 100% for all other Covered Expenses that the insured incurs for the rest of the year, up to the Maximum Benefit.

The Deductible and any required Copays do not apply toward the Copayment Limit. In addition, the following expenses do not count toward the Copayment Limit. Even when we pay other expenses at 100%, the percentage we pay for these expenses will not be increased.

- expenses for private duty nursing;
- pre-authorization penalties; and
- expenses paid at 100%.

Family Copayment Limit

Once the Per Family Yearly Copayment Limit has been satisfied, you and each insured member of your family will be considered to have met his or her Per Person Copayment Limit for the rest of that year.

The Maximum Benefit

The Maximum Benefit Per Person is the maximum amount of benefits we will pay for each insured for all Covered Expenses incurred while he or she is insured under this Plan at any time. If there is a break in insurance coverage, only the portion of the Maximum Benefit remaining on the date of termination of coverage will be reinstated.

After we have paid an insured some benefits, we will adjust his or her Maximum Benefit as follows:

1. The Maximum Benefit will be fully restored if the insured gives us proof of his or her good health by our standards. This proof must be approved by us before the Maximum Benefit will be restored. It must be given at the insured's expense.

2. After the insured has gone 24 months without any medical care for an injury or sickness, the Maximum Benefit will be fully restored for that injury or sickness.

EXPENSES THAT WE LIMIT

The benefits we pay for **Covered Expenses** incurred for the following are limited:

1. Psychiatric Care. Covered Expenses incurred for psychiatric care are limited as follows:

   a. For Covered Expenses incurred for care received while the insured is an in-patient in a hospital as defined by the Mental Hygiene Law, we will pay for 30 days of active treatment in any one year.

   b. For Covered Expenses incurred for out-patient visits, we will pay $40 or the actual charge, if less. We do not cover more than 52 treatments in any one year.

      Covered Expenses will be paid for out-patient care provided:

      - At a facility certified by the Commissioner of Mental Hygiene;
      - At a facility operated by the Office of Mental Health;
      - By a licensed psychiatrist or psychologist, or a professional corporation thereof; or
      - By a certified social worker, within the scope of his or her license.

   c. For out-patient crisis intervention services. We will pay for 3 visits per year, if a provider who we pay benefits for certifies that the visit was the result of a psychiatric emergency. We will pay $60 or the actual charge, if less.

      All in-patient care and partial hospitalization must be pre-authorized, or a penalty will apply as stated above.

      These limits apply to Network or Non-Network Providers.

2. Alcoholism and Drug Abuse. Covered Expenses incurred for alcoholism and drug abuse are limited as follows:

   a. For Covered Expenses incurred for detoxification while the insured is an in-patient in a hospital or a detoxification facility, we will pay for 7 days in any one year.

   b. For Covered Expenses incurred for rehabilitation services while the insured is an in-patient in a hospital, we will pay for 30 days in any one year.

   c. For Covered Expenses incurred for out-patient treatment, we will pay for 60 visits in any one year (of which 20 visits may be for family members).

   Benefits for in-patient and out-patient treatment of substance abuse will only be paid if the treatment is provided by:

   - Facilities in New York which are certified by the Division of Alcoholism and Alcohol Abuse, or the Division of Substance Abuse Services; and
   - Facilities in other states which are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) as alcoholism or substance abuse treatment programs.

3. Spinal Column Care. We pay up to a maximum 15 visits per year for each insured for care to manually or mechanically detect and correct distortion, misalignment or partial dislocation of the spinal column and related physical therapy or treatment.

4. Foot Care. The maximum benefit we pay is $2,000 per year for each insured for one or more of the following procedures:

   a. An open cutting operation for the treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;

   b. Removal of nail roots; or

   c. If the insured has a metabolic or peripheral vascular disease, the treatment of corns, calluses or toenails.

COVERED EXPENSES

To be a Covered Expense, an expense must be:

- reasonable; and
- incurred for the necessary Medical Care of an insured; and
- incurred only for the Medical Care and to the extent described below.

Any expense we list under **Expenses We Do Not Cover** is not a Covered Expense.

Hospital Expenses

We cover charges a Hospital makes on its own behalf for:

- Room and Board Services. These include these services: general nursing care; dietary services; admission services; record keeping services; housekeeping services; and any other regular daily in-patient service the Hospital provides for the type of room the insured is in.

  If any daily charge for a private room exceeds the Hospital's daily charge for its most common semi-private room, the excess is not a Covered Expense.

- Other Services. These are all other services or supplies a Hospital provides.

In the case of a confinement for substance abuse, if the Hospital does not have established facilities for major surgery there is a limit on how much we cover for each day of the confinement. This limit is $250. It applies to Room and Board Services and Other Services combined. Any excess is not a Covered Expense.

Other Medical Expenses

We cover charges made for the following:

- Services of a doctor or an anesthetist. But for expenses incurred for doctors' visits while the insured is an in-patient in a Hospital or similar place, we will only cover up to four visits by all doctors combined in a two day period. Any excess is not a Covered Expense.

- Services of a licensed physiotherapist or licensed occupational therapist, but only to restore or improve lost function following an injury or sickness.

- Services of a qualified speech therapist to restore speech loss, or correct an impairment, due to (a) a birth defect for which corrective surgery has been performed, or (b) an injury or sickness except a mental, psychoneurotic or personality disorder.

- Services of a licensed or board certified psychologist.

- Services of a certified nurse-midwife under qualified medical direction, affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the New York Public Health Law.

- Services of a licensed physical therapist.

- Private duty nursing services provided by a person licensed to provide such service. But there is a limit on how much we cover for these services. This limit is $125 per day. Any excess expense is not a Covered Expense. And such services provided by a person who is also an employee of or affiliated with the Hospital or similar place in which the insured is an in-patient will not be a Covered Expense.

- Services provided as a hospital out-patient in connection with an injury or sickness in a medical emergency.

- Services and medications used for non-experimental cancer chemotherapy and cancer hormone therapy.

- Preadmission tests performed in a hospital facilities prior to scheduled surgery.

- For treatment of correctable medical conditions causing infertility, except for Embryo Transplant services including, but limited to GIFT and In Vitro Fertilization.

- Second surgical opinion by a qualified doctor on the need for surgery.

- The following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a doctor or other licensed health care provider:

    - lancets and automatic lancing;
    - glucose test strips;
    - blood glucose monitors;
    - blood glucose monitors for the visually impaired;
    - control solutions used in blood glucose monitors;
    - diabetes data management systems for management of blood glucose;
    - urine testing products for glucose and ketones;
    - oral anti-diabetic agents used to reduce blood sugar levels;
    - alcohol swabs;
    - syringes;
    - injection aids including insulin drawing up devices for the visually impaired;
    - cartridges for the visually impaired;
    - disposal insulin cartridges and pen cartridges;
    - all insulin preparations;
    - insulin pumps and equipment for the use of the pump including batteries;
    - insulin infusion devices;
    - oral agents for treating hypoglcemia such as glucose tablets and gels; and
    - glucagon for injection to increase blood glucose concentration.

- Diabetes self-management education, including education relating to proper diets. Coverage is limited to visits which are medically necessary upon diagnosis of diabetes, or if the doctor diagnoses a significant change in the insured's symptoms or conditions which require changes in the insured's self-management, or if re-education or refresher education is necessary.

- Nutritional supplements (formula) as medically necessary for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria when administered under the care of a doctor.

- Allergy tests for diagnosing disease.

- Lab tests.

- Mastectomy or lymph node dissection, on the same basis as any other surgical procedure. Covered Expenses include:

  1. In-patient Care. We pay benefits for in-patient care for not less than:

     a. 48 hours after a simple mastectomy or lymph node dissection; or

     b. 72 hours after a modified radical mastectomy.

     A longer in-patient stay will be covered if it is determined to be necessary. The additional stay must be pre-authorized as required by this Plan. Out-patient surgery or an early discharge will be covered if the attending doctor, in consultation with the insured, determines that a shorter length of stay is medically appropriate.

  2. Reconstructive Surgery. We pay benefits for Reconstructive surgery following a mastectomy. Covered Expenses include surgery on one breast or both to reestablish symmetry between the two breasts, including, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

- For pregnancy on the same basis as an illness, including the following:

  1. In-patient Care. Following the delivery of a child, we will pay benefits for Covered Expenses incurred by the mother and her newly born child(ren) in a Hospital or other licensed facility for not less than:

     a. 48 hours after a vaginal delivery; or

     b. 96 hours after a cesarean section.

     We will pay in-patient benefits for a greater length of time if the attending doctor determines that it is medically necessary.

  2. Post-Discharge Care. If the attending doctor, in consultation with the mother, approves a shorter hospital stay, we will pay benefits for at least two Post-discharge visits, at least one of which must be a home visit. Post-discharge care will be provided by an appropriately licensed and trained person, and includes, but not limited to the following:

     a. physical assessment of the mother and the newborn child(ren);
     b. parent education;
     c. assistance and training in breast and bottle feeding;
     d. education and services for complete childhood immunizations; and
     e. any necessary and appropriate clinical tests, including submission of a metabolic specimen satisfactory to the state laboratory.

     Early discharge and post-discharge care must be provided in accordance with nationally recognized guidelines.

- The following Preventive Care services:

  - Doctors' office visits for routine physical exams, including routine injections, inoculations, immunizations, routine x-rays, laboratory tests and multiphasic screening; and

    i) Upon the recommendation of a physician, a mammogram at any age for women having a prior history of breast cancer or whose mother or sister has a prior history of breast cancer; and

    ii) a baseline mammogram for women age 35 but under 40 years; and

    iii) a mammogram once every two years (or more frequently, if recommended by a doctor) for women age 40 but under 50 years; and

    iv) a mammogram once a year for women 50 years of age or older.

  - An annual cervical cytology screening for women age 18 or older, including an annual pelvic examination, collection and preparation of a pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the pap smear.

- An annual colorectal cancer screening starting at age 50.

  - Preventive and Primary Care Services from birth up to age 19. We cover an initial hospital checkup and well child visits in accordance with the recommendations of the American Academy of Pediatrics.

    We will cover the following services during each visit: a medical history, a complete physical examination, development assessment, anticipatory guidance, and appropriate immunizations and laboratory tests. We will also cover necessary immunizations as follows: diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, hemophilus influenza type b, and hepatitis b.

    We pay 100% of these Covered Expenses. No deductible Copay, or Copayment Percent applies to any of these services.

  The most we pay for all Covered Expenses incurred in connection with preventive care services is $250 per year for each insured. This limit does not apply to mammograms or cytological screening or to Pediatric Preventive and Primary Care services.

- Diagnostic x-ray exams.

- X-ray, radium and radioactive isotope therapy.

- Prescription drugs and prescription medicines.

- Artificial limbs and eyes, and their repair or (at our option) replacement.

- Casts, splints and surgical dressings.

- Orthopedic appliances (such as trusses, crutches and braces).

- Rental or purchase (at our option) of hospital type bed, wheelchair, iron lung or similar durable medical equipment which is: (a) used solely by the insured for the treatment of his or her injury or sickness; and (b) generally not useful to a person who is not injured or sick. But the most we will pay for these expenses during the insured's lifetime is $10,000.

- Whole blood or blood plasma, except that which is replaced by or for the insured.

- Oxygen and the rental of equipment for giving it.

- Anesthesia and fluids needed for surgery.

- Local ambulance services.

- Transportation by rail, ambulance, or plane from the place where an acute injury or sickness needing specialized attention occurs to the nearest hospital equipped to furnish the needed treatment. But that mode of transportation must be medically necessary. And if these expenses are more than $2,500 in connection with any one period of Hospital Confinement, the excess is not a Covered Expense. A previous confinement and a current one are treated as one period of confinement unless: (a) they are due to unrelated causes; (b) they are separated by at least 90 days; or (c) in your case, they are separated by your return to active, full-time work for at least one full day.

- Services provided by an Ambulatory Surgical Center.

- Services provided by a Birthing Center.

- The following services provided by or through a certified Home Health Care Agency for an insured in his or her home:

  1. Any service listed as a covered service under this "Other Medical Expenses" provision;

  2. Part-time home health aide services, up to 20 hours per week;

  3. Respiratory therapy;

  4. Audiology;

  5. Medical social work;

  6. Nutrition counseling;

  7. Minor equipment, such as commodes and walkers.

  We cover these services only if:

  - the home health care is according to a written plan established by a doctor; and

  - that doctor certifies that confinement in a Hospital or similar place would have been required if home health care were not provided; and

  - the insured is under the continuous care of that doctor during the period of home health care.

- Room and board and other services provided by a Convalescent Care Facility for an insured while an in-patient, up to these limits:

  1. A limit per day of 50% of the most common daily semi-private room charge of the Hospital in which the insured was confined before entering the Facility.

  2. A limit of 90 days of convalescent care for any one injury or sickness.

We cover these services only if:

- the insured was a Hospital in-patient for at least 3 days in a row before entering the facility; and
- benefits were payable under this Coverage for that Hospital stay; and
- the insured enters the facility within 14 days after leaving the Hospital; and
- the stay results from the same injury or sickness which caused the Hospital confinement; and
- a doctor who cared for the insured during the Hospital stay recommends, approves and supervises the convalescent care.

A new 3 day Hospital stay must precede a later period of convalescent care if the later care:

- is totally unrelated to the earlier period of care; or
- begins more than 14 days after the earlier care ends; or
- begins after the insured has resumed his or her normal duties and activities. (For you, this means completing at least one day of active, full-time work.)

- The following Hospice Care Services provided under the Hospice Care Program by a Hospice or a Hospice Team:

1. Up to 210 days for: In-patient Hospice Care Services provided in a hospice or in a hospital; and Out-patient Hospice Care Services including drugs and medical supplies; and
2. Bereavement Benefits for counseling services provided before or after the death of the person who had the terminal illness to the members of his or her family to assist them in dealing with the person's death. We will pay up to 5 visits for these services provided to all members of the family.

All periods of Hospice Care in a Hospice Care Program, in-patient and out-patient, are treated as one period of Hospice Care unless they are separated by at least 90 days.

We cover these services only if:

- The insured's doctor:
  - certifies that he or she has a terminal illness and is expected to live 6 months or less. If the insured lives longer than 6 months, this benefit will be extended if:
    - i) his or her doctor again certifies that the insured has 6 months or less to live; and
    - ii) the extension is approved by us. An extension of this benefit does not mean that the insured is entitled to additional benefits. It means that the current benefit will not cease because the insured lived longer than 6 months; and
  - recommends admission to a Hospice Care Program.

- The Hospice Care Program is provided:
  - at home by a Hospice Team, under a program which is available 24 hours a day, 7 days a week; or
  - as an in-patient in a Hospice.
- The Hospice Care Services are ordered by the doctor who is directing the Hospice Care Program.
- The charges are made by the Hospice or charged for under the Hospice Care Program.
- The Hospice Care Services are provided within 6 months from the date the person entered or re-entered (after a period of remission) the Hospice Care Program. A "period of remission" means a period during which:
  - the progression of a terminal illness stops; or
  - there is real improvement in the condition of the person.

  We do not pay for services or supplies provided during a Period of Remission. This does not apply if the person is not discharged from the Hospice Care Program.

EXPENSES WE DO NOT COVER

We do not cover expenses for the following Medical Care, and none of these expenses will figure in any calculation of benefits. We do not cover expenses:

1. For Medical Care not recommended and approved by a doctor.

2. For Medical Care received in a facility owned or run by or furnished at the expense of the U.S. Government or one of its agencies. But this does not apply to Covered Expenses furnished by a Veterans Administration hospital for non-service connected disabilities.

3. For Medical Care for which the insured- without this insurance - would not be legally obligated to pay.

4. For Medical Care for cosmetic purposes.

   But we do cover:

   - Cosmetic treatment of an injury for up to 24 months after the accident, if the treatment starts within 90 days after the accident.

   - Reconstructive surgery which is incidental to or follows an injury or a sickness. But we will not cover such surgery if it is performed mainly to improve the mental or emotional state of the insured.

   - Reconstructive surgery because of a congenital disease or birth defect of an insured dependent child which impairs a function of the body.

5. For dental care or treatment.

   But we do cover:

   - Hospital services for in-patient care received while confined for dental care or treatment.

   - Dental care or treatment of an injury to the jaw or sound natural teeth for up to 24 months after the accident.

6. For eye refractions, surgical correction of a refractive disorder of the eye, eyeglasses, contact lenses, hearing aids, or their fittings.

   But we do cover the first pair of eyeglasses or contact lenses which the doctor prescribes after cataract surgery.

7. For an injury or a sickness due to war or armed conflict which involves one or more countries.

8. For an injury or a sickness which arises out of or in the course of your employment for which worker's compensation, employers' liability or occupational disease law benefits are paid.

9. For services furnished by one of these persons: (a) you or your spouse; or (b) your or your spouse's parent, child, brother or sister.

10. For Medical Care received while outside the United States, its possessions, or the countries of Mexico and Canada. But we do cover Medical Care received during the first 60 days of such an absence.

11. For custodial care or care to help in the routine of daily living.

12. For routine nursery and pediatric care of a newborn child. But we do cover these services for routine care received before the child leaves the Hospital in which he or she was born: (a) Hospital nursery services; (b) routine tests and doctors' examinations; and (c) circumcision. And we also cover routine pediatric care as described elsewhere in this Section.

13. For routine health examinations, physical check-ups or preventive care, except for those services specifically included elsewhere in this Section.

14. For routine treatment of the feet, except for those services specifically included elsewhere in this section.

15. For a Pre-Existing Condition. This is: (i) an injury or a sickness or a related sickness or injury or pregnancy for which the insured consulted with a doctor, took medicine, or received other Medical Care or advice within 6 months before becoming insured; or (ii) the existence of symptoms which would cause an ordinary prudent person to seek medical advice, diagnosis, care or treatment within 6 months before becoming insured.

    We will cover expenses incurred for such a condition without this limit after a person has been insured under this Coverage for 12 months in a row.

    This provision will not apply to:

    (a) congenital anomalies of a covered dependent child; or

    (b) any person who became insured under this Coverage on its effective date, and who was insured under any employer-sponsored medical expense plan that was continuous to within 90 days of the Effective Date of this Plan.

    For any other covered person, the time that the person was covered under Qualifying Previous Coverage may be credited under this provision. However, coverage under the Qualifying Previous Coverage had to be continuous to within 90 days of the person's effective date under this Coverage. The 90 day period does not include any service waiting period required by your Employer in order to be eligible for this Plan.

    This provision will not apply to an adopted child, or child placed for adoption, if the child becomes insured when he or she is first eligible under this Plan.

16. For care to manually or mechanically detect and correct distortion, misalignment or partial dislocation of the spinal column and related physical therapy or treatment, except as specifically included elsewhere in this section.

17. For Medical Care provided by your or your insured dependent's employer, labor union, or similar group, for which no charge would normally be made in the absence of this insurance.

18. For Medical Care of an injury due to taking part in a felony.

WHEN WE EXTEND BENEFITS

If the insured is totally disabled on the day his or her coverage ends, these Major Medical benefits will be available for the condition which caused that disability just as if coverage had not ended. This extension of benefits will end on the first of these dates:

- 12 months from the date coverage ended; or
- the date insured is no longer totally disabled; or
- the day before he or she becomes insured for that condition under any other group health care plan which provides health care benefits or services and which is arranged through an employer.

SECTION 5

COORDINATION OF HEALTH CARE BENEFITS

WHEN WE COORDINATE WITH OTHER PLANS

HOW WE COORDINATE AMONG PLANS

HOW WE COORDINATE WITH MEDICARE

WHEN WE COORDINATE WITH OTHER PLANS

You or your insured dependents may also have health care coverage under another Plan. If so, we coordinate what we pay under this Plan with the benefits from these other Plans. As a result, we may reduce what we pay under this Plan so that an insured never receives a total, from all Plans, of more than 100% of allowable expenses incurred during a year.

Here are some basic terms that you should know:

Health Care medical care.

An **allowable expense** is any necessary, reasonable and customary item of expense covered in full or in part under a Plan. (When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service will be treated as both an allowable expense and a benefit paid.)

A **Plan** includes any health care insurance, benefits or services provided through one or more of the following:

- group, blanket or franchise insurance;
- group service plans or other group prepayment coverage;
- any other program of benefits or services for individuals as a group, whether insured or not;
- basic motor vehicle no-fault insurance, whether group or individual; or
- any government program or coverage required or provided by law, except Medicare and Medicaid. (See the end of this Section for details on how we coordinate with Medicare coverage.)

This Plan includes all the Coverages under the Policy which provide health care expense benefits.

HOW WE COORDINATE AMONG PLANS

To coordinate among Plans, we must determine the order in which the various Plans will pay benefits.

Another Plan will not affect our paying benefits if our rules call for us to determine benefits first. But if the benefits of the other Plan are to be paid before those of this Plan, the benefits of this Plan will be reduced as described above.

These are our rules to determine the order of paying benefits:

1. A Plan which does not have a coordination of benefits provision pays before a Plan which has one.

2. A Plan which covers a person other than as a dependent pays before a Plan which covers him or her as a dependent.

3. A Plan which covers a child as the dependent of a person whose month and day of birth occurs earlier in the year pays before a Plan which covers the child as the dependent of a person whose month and day of birth occurs later in the same year. If both parents have the same birthday, the Plan which has covered the parent longer pays before the Plan which has covered the other parent for a shorter period of time. But, if the other plan does not have this rule, a Plan which covers a child as a dependent of the father pays its benefits before a Plan which covers the child as a dependent of the mother.

   But in the case of a dependent child whose parents are separated or divorced:

   - Sometimes there is a court decree which sets financial responsibility for the child's health care expenses. If this is the case, a Plan which covers the child as a dependent of the parent with that responsibility pays before any other Plan which covers the child as a dependent.

   - If the parent with custody of the child has not remarried, a Plan which covers the child as a dependent of that parent pays before a Plan which covers the child as a dependent of the other parent.

   - If the parent with custody of the child has remarried, a Plan which covers the child as a dependent of that parent pays before a Plan which covers the child as a dependent of the step-parent. And a Plan which covers the child as a dependent of the stepparent pays before a Plan which covers the child as a dependent of the parent without custody.

   - If a court decree states that the parents share joint custody, without stating that one of the parents is responsible for the child's health care expenses, the plans covering the child shall determine the order of the benefits as if the child's parents are not separated or divorced.

4. A Plan which covers a person as an active employee, or as the dependent of such an employee, pays before a Plan which covers that same person as a retired or laid off employee, or as the dependent of such an employee.

   If the other Plan does not have the rule described above, and if as a result, the Plans do not agree on which Plan should pay first, this rule is ignored.

5. If a person who is covered under a right of continuation under Federal or State law is also covered under another Plan, the order of paying benefits will be determined as follows:

   - A Plan which covers a person as an employee (or as that person's dependent) pays first.

   - The Plan providing the continuation coverage pays second.

6. If the above rules do not set an order of payment, then the Plan which has covered the person longer pays first.

   To administer this provision, we have the right to:

   - recover any sum we paid that another Plan should have paid; and

   - repay any party for a payment made by that party, when the payment should have been made by us; and

- give or get information we need to coordinate among Plans. (You are required to provide us with any information we need to pay the claim.)

HOW WE COORDINATE WITH MEDICARE

This provision applies only when Medicare pays its benefits before this Plan. When Medicare is required by federal law to pay after this Plan, this provision will not apply.

When a person is eligible for Medicare, we figure benefits under this Plan as follows:

1. First, we reduce the person's health care expenses by the amount of Medicare benefits available for those same expenses. (If the person has not enrolled for all parts of Medicare, we reduce his or her health care expenses by the amount that Medicare would have paid if he or she had enrolled.)

2. Then we calculate benefits just as if the person were not eligible for Medicare. But we do this based on the reduced amount of expenses.

There is one exception to No. 1 above. If a person stays in a private room in a Hospital, we apply the Medicare benefits against this Plan's daily limit for a private room rather than against the Hospital's actual charges for that room. This means that the difference between this Plan's private room limit and what the Hospital charges for that room is not paid for by this Plan.

SECTION 6

HOW TO FILE A CLAIM

NOTIFY US OF A CLAIM

PROOF OF LOSS

WE CAN REQUIRE EXAMINATIONS AND AUTOPSIES

HOW WE PAY CLAIMS

LEGAL ACTIONS

ASSIGNMENTS

RIGHT OF RECOVERY

NOTIFY US OF A CLAIM

To make a claim for benefits, you must notify us in writing. We must receive your notice within 30 days after a covered loss starts, or as soon after as is reasonably possible.

PROOF OF LOSS

When we receive the notice, we will send our forms for filing proof of loss and ask that they be filled out. If we do not send you these forms within 15 days after we are notified of the claim, you can write to us with this information: the date the injury occurred or the sickness began, the nature and extent of the loss, and enough information to identify the insured.

But we must receive written proof of the loss within 90 days after the loss.

Even if we do not receive the proof within the 90 days, we will not refuse or reduce the claim if we receive it as soon as it is reasonably possible.

WE CAN REQUIRE EXAMINATIONS AND AUTOPSIES

While the claim is pending, we have the right to have the person examined, at our expense, by a doctor we choose. We have the right to do this when and as often as we need to process the claim.

In claims for loss of life, we can require an autopsy, at our expense, unless it is not permitted by law. We also have the right to examine the body, and to investigate the circumstances of the death.

HOW WE PAY CLAIMS

All benefits are paid as soon as we receive proof of the loss.

Benefits for loss of your life are paid to the named beneficiary if he or she survives you. Otherwise, we will pay your estate.

We pay all other benefits to you, if you are alive. If you are not living, we pay your estate.

If a benefit is to be paid to your estate, we may - at our option - pay the benefit to one or more of these relatives of yours: spouse, father, mother, children, brother or sister.

Sometimes a benefit is to be paid to a person who is a minor or not competent to give a valid release. If this happens, we may - at our option - pay the benefit to any institution or person who, in our opinion, has been caring for or supporting the person. We may do this until the person's legal guardian makes a claim.

Once we make a payment under the terms of the Policy, we have no further liability for the amount paid.

You can ask us to pay health care benefits directly to the party who provided the care. The request must be in writing. If we pay as you asked, the payment will release us from any other claim for the benefits paid. If you want to change the request, it must be in writing. And we must receive it no later than the time for filing proof of loss.

Non-custodial parent

If coverage is provided to a child who does not live with you, pursuant to a court or administrative order, the following provisions will apply to the custodial parent instead of you:

1. "Notify Us of a Claim" and "Proof of Loss" - the custodial parent may notify us directly and provide the required proof of loss as required above.

2. "How we pay Claims" - We will pay the health care benefits directly to:

   (a) The custodial parent;

   (b) The provider, if the custodial parent has requested the benefit to be paid to the provider in writing; or

   (c) To the Medicaid Agency, if the benefits have been provided or paid for or by the Agency.

LEGAL ACTIONS

No legal action for benefits may be brought against us:

(a) until at least 60 days after proof of loss is sent to us as required; or

(b) more than 3 years after the time for submitting proof has ended.

ASSIGNMENTS

Except for certain loss of life benefits, the insurance and benefits under this Plan may not be assigned. But this does not stop us from paying health care benefits to others at your request. (See "How We Pay Claims".)

RIGHT OF RECOVERY

A third party may be liable or legally responsible for expenses incurred by an insured for an injury or a sickness.

Benefits may also be payable under the Health Care Coverages under this Plan for these expenses. When this happens, we may, at our option:

1. Recover from the insured any benefits paid under the Health Care Coverages which the insured is entitled to receive from the third party. We will have a first lien upon any recovery, whether by settlement, judgment or otherwise, that the insured receives from:

   (a) the third party; or

   (b) the third party's insurer or guarantor; or

   (c) any uninsured motorist insurance.

   This lien will be for the amount of benefits paid by us for Medical Care of the injury or sickness for which the third party is liable or legally responsible. If the insured:

   (a) makes any recovery as set forth in this provision, that is specifically identified in the recovery as the amount paid by us for the same medical services or benefits; and

   (b) fails to repay us fully for any benefits paid under this provision;

   then the insured will be personally liable to us to the extent of the recovery up to the amount of the first lien. The insured must cooperate fully with us in claiming our rights to recover.

2. Before any benefits are paid by us, require the insured to provide all information and sign and return all documents necessary to carry out our rights under this provision.

SECTION 7

WHEN INSURANCE ENDS

WHEN YOUR INSURANCE ENDS

WHEN YOUR DEPENDENTS INSURANCE ENDS

SPECIAL CONTINUATION OF INSURANCE COVERAGE

FOR A HANDICAPPED CHILD

FOR YOUR DEPENDENTS IF YOU DIE

IF YOU ARE NO LONGER ELIGIBLE

IF YOUR DEPENDENTS ARE NO LONGER ELIGIBLE

WHEN YOUR INSURANCE ENDS

Your insurance under a Coverage will end on the first of these dates:

- the last day of the month which falls on or next after the date your employment ends. (This is the date you stop active, full-time work, unless the Policy provides otherwise. Under certain circumstances your coverage may continue. Check with your Benefits Administrator to see what the Policy provides.)
- the date your Employer's Plan under the Policy (or that Coverage under the Plan) terminates.
- the date your Employer's Plan under the Policy is changed to end coverage for your class.
- the last day of the month which falls on or next after the date you are no longer in an eligible class for that Coverage.
- the last day of the period for which your Employer has paid, when due, the required coverage charges on your behalf.
- in the case of your insurance under the Major Medical Insurance Coverage, the date you elect Medicare as your primary coverage. This applies when federal law requires Medicare to pay its benefits after this Plan but allows you to choose Medicare as your primary coverage.

See the next Section for details on how you may obtain an individual policy when group coverage ends.

WHEN YOUR DEPENDENTS INSURANCE ENDS

Your dependent's insurance under a Coverage will end on the first of these dates:

- the last day of the month which falls on or next after the date your dependent is no longer an eligible dependent.
- the date your insurance ends. (But this does not apply if your insurance ends because you elected to have Medicare as your primary coverage.)

WHEN INSURANCE ENDS

- the date your Employer's Plan under the Policy (or that Coverage under the Plan) terminates.
- the date your Employer's Plan under the Policy is changed to end coverage for your dependent's class.
- the last day of the month which falls on or next after the date your dependent is no longer in an eligible class for that Coverage.
- the last day of the period for which your Employer has paid, when due, the required coverage charges on your dependent's behalf.
- in the case of your spouse's insurance under the Major Medical Insurance Coverage, the date he or she elects Medicare as his or her primary coverage. This applies when federal law requires Medicare to pay its benefits after this Plan but allows the insured to choose Medicare as his or her primary coverage.

See the next Section for details on how your dependent may obtain an individual policy when group coverage ends.

SPECIAL CONTINUATION OF INSURANCE COVERAGE

FOR A HANDICAPPED CHILD

Your child's health care insurance will not end just because the child has reached the age limit shown in Section 2, if he or she:

- is not able to earn his or her own living as a result of physical handicap, mental illness, developmental disability or mental retardation, as defined in the New York mental hygiene law; and
- became so handicapped before reaching that age limit; and
- is chiefly dependent on you for support and maintenance.

Within 31 days after your child reaches the age limit, you must send us proof of his or her dependency and handicap.

We may ask for more proof of the child's dependency and handicap. But after the child's insurance has been continued under this provision for at least 2 years, we will not ask for proof more than once each year.

This continued coverage will end on the first of these dates:

- the date the child is no longer handicapped or dependent on you;
- the date the child's insurance would end for any reason listed under **When Your Dependents Insurance Ends** - other than reaching the age limit. (For example, the date your insurance ends.)

FOR YOUR DEPENDENTS IF YOU DIE

Health care insurance continues for up to 180 days after your death for your dependents who are insured at your death. During this time, no premium payments are required under this provision.

This insurance will end for all of your dependents on the first of these dates:

- 180 days after your death.
- The date your spouse remarries.
- The date your Employer's Benefit Plan under the Policy (or the Coverage under the Plan) terminates.
- The date your Employer's Benefit Plan under the Policy is changed to end insurance for your dependent's class.

This insurance will also end for any dependent who:

- is no longer eligible under the Plan as a dependent; or
- becomes eligible or insured under any other group health care plan which provides health care benefits or services and which is arranged through an employer.

Your dependents' insurance will be subject to any changes in the Plan after your death.

The right to convert to an individual policy will be available when this continued insurance ends.

If your or your dependents insurance is being continued as allowed by state law for a reason other than your death and you die while the insurance is being continued, this **FOR YOUR DEPENDENTS IF YOU DIE** provision will not apply. If a state law allows for continued coverage for your dependents because of your death and the dependents elect to continue the coverage allowed by that law, this provision and the one required by state law will be effective at the same time. The following provisions of this section explain under what circumstances insurance may be continued for you or your dependents because of a state law, if any.

IF YOU ARE NO LONGER ELIGIBLE

The provision that follows is required by state law and applies to you if your Employer's group health plan is not subject to COBRA (the federal Consolidated Omnibus Budget Reconciliation Act of 1985). See your Employer for details.

If your health care coverage ends because your employment or membership in an eligible class terminates, you may continue that insurance for both you and your insured dependents for up to 18 months. To do this, you must:

- make a written request to your Employer to continue that insurance. You must make that request within 60 days after the later of: (a) the date your employment or eligibility ends; or (b) the date you are given notice of the right of continuation by your employer; and
- pay the full cost of the continued insurance. We will tell you when and how to pay.

WHEN INSURANCE ENDS

While insurance is being continued, you will be considered a member of the class to which you belonged on the date insurance would have ended. This class determines the coverages and the benefit amounts which will apply during this time. All of the terms of the Policy that applied to your health care insurance will still apply.

Insurance will end on the first of these dates:

- The date you become eligible again for health care insurance under this Plan.
- The date you become eligible for health care insurance under any other group health care plan which does not contain any exclusion or limitation with respect to a pre-existing condition with respect to you or your insured dependents.
- The end of the 18 month period after your insurance would have ended. (But if you were determined to have been disabled under the Social Security Act at the time of termination, your insurance will continue until the end of the 29 month period after your insurance would have ended; however, you must notify your employer within 60 days of receiving that determination.)
- The last day of the period for which the premium to continue insurance has been paid to us.
- The premium due date that falls on or after the date you become eligible for Medicare.
- The date insurance would end for any other reason listed under **When Your Insurance Ends** or **When Your Dependents insurance Ends**.

The right to convert to an individual policy will be available when this continued insurance ends.

IF YOUR DEPENDENTS ARE NO LONGER ELIGIBLE

The provision that follows is required by state law and applies to you if your Employer's group health plan is not subject to COBRA (the federal Consolidated Omnibus Budget Reconciliation Act of 1985). See your Employer for details.

If your dependents' health care insurance ends because: you die; you are divorced or legally separated; your insured child ceases to qualify as a dependent under the terms of the Policy; or you become eligible for Medicare, insurance may be continued for those dependents for up to 36 months. To do this, your dependents must:

- make a written request to your Employer to continue that insurance. Your dependent must make that request within 60 days after the later of: (a) the date of terminating event; or (b) the date your dependent is given notice of the right of continuation by your employer; and
- pay the full cost of the continued insurance. We will tell your dependents when and how to pay.

While your insurance is being continued, your former spouse or dependents will be considered members of the class to which you belong, or to which you belonged on the date insurance would have ended. This class determines the coverages and the benefit amounts which will apply during this time. All of the terms of the Policy that applied to your health care insurance will still apply.

Insurance will end on the first of these dates:

- The date your dependent becomes eligible again for health care insurance under this Plan.
- The date you become eligible for health care insurance under any other group health care plan which does not contain any exclusion or limitation with respect to a pre-existing condition with respect to you or your insured dependents.

- The end of the 36 month period after insurance would have ended.
- The last day of the period for which the premium to continue this insurance has been paid to us.
- The date your insurance would end for any other reason listed under **When Your Insurance Ends** or **When Your Dependents Insurance Ends**.

The right to convert to an individual policy will be available when this continued insurance ends.

SECTION 8

HOW TO CONVERT TO INDIVIDUAL INSURANCE

CONVERTING MEDICAL CARE INSURANCE

CONVERTING MEDICAL CARE INSURANCE

In most cases, you may convert to your own policy of Medical Care insurance with us if:

- your group Medical Care insurance ends; and
- you have been insured under the group coverage for at least 3 months in a row.

No proof of good health is needed.

We will issue the policy subject to these terms:

1. That policy, and the coverage it provides, will be that which is normally made available for conversions at the time you apply. If you were insured for basic hospital or basic surgical expense insurance under the group policy, you will be able to convert to your own policy of basic hospital or basic surgical expense insurance. If you were insured under a group major medical insurance policy, you will be able to convert to your own policy of major medical insurance. If you were insured under a group comprehensive medical policy, you will be able to convert to your own policy of basic hospital, basic surgical and major medical insurance. The policy will meet the minimum requirements of the state where the Group Policy was delivered. We will provide you with the benefits available and the premium rate for the policy.

2. You must apply for the policy and pay the first premium within 45 days after your group coverage ends. The individual policy will take effect on the date your group coverage ends.

   If you are not given written notice of the conversion right and the time period for applying by your employer or us either before or after 15 days of the date the insurance ends, you will have 45 days from the date notice is given to you to apply. If the notice is not given within 90 days of the date the insurance ends, you will not be allowed to convert after the end of the 90 days. Notice will be deemed received by you if it is given to you or mailed to your last known address by your employer or us.

3. The policy will include your eligible dependents who were insured under your group Medical Care coverage.

4. The premium for your policy will be based on our normal rate for the class of risk and ages of the persons to be covered, and the type and amount of insurance applied for. We use the rate in effect on the later of: (a) the date of the application; or (b) the date the new policy takes effect.

5. We will not allow a person to convert who is eligible for Medicare. We will also not allow a person to convert who is:

   - insured under other coverage. This includes insurance plans, subscriber plans and prepayment types of plans and programs; or

   - eligible for similar benefits under a group type plan, whether insured or uninsured,

   if the converted policy would duplicate benefits or make the person overinsured. (We determine this according to standards on file with the state insurance department where the Group Policy was delivered.)

   And, we will not allow the person to convert if the Employer's Benefit Plan under the Policy or the Medical Care coverage under the Benefit Plan is ended and the coverage is replaced at once with similar group coverage whether insured or uninsured.

6. During the first 2 years the policy is in force, we may request information before a premium due date to see if an insured has other similar coverage. If we do not get this information, we may refuse to pay for an expense in question. We can reduce benefits under the new policy by the amount of any benefits payable for the same expenses under the group coverage. And during the first year of the new policy, we can reduce benefits so that they do not exceed the benefits that would have been paid under the group coverage. Any condition excluded under the group coverage may be excluded in the new policy.

A dependent may convert to his or her own policy as follows:

- at your death, your spouse may apply for a policy to cover all eligible members of your family unit who are then insured under your group Medical Care coverage.

- after divorce or annulment, your spouse may apply for his or her own policy.

- when your child marries or reaches the age limit under your coverage, he or she may apply for his or her own policy.

The terms of the policy to be issued and the conditions you must meet in order to convert also apply to these dependents.

The following information may be required to be provided by your Employer under the Employee Retirement Income Security Act of 1974 (ERISA). It is provided as a courtesy for your Employer. It is not a part of the Certificate of Insurance described in the preceding pages which Anthem Health of New York is required to provide under state law.

GENERAL INFORMATION

STATEMENT OF ERISA RIGHTS

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

(i) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.

(ii) Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and the beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court.

In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful the court may order the person you have sued to pay court costs and fees. If you lose, the court may order you to pay these costs and fees (e.g. if it finds your claim is frivolous). If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

NOTICE OF DENIAL OF CLAIM

If any benefits are denied, either in whole or in part, notification of the specific reason or reasons of the denial will be given along with reference to the pertinent plan provisions on which the denial is based. Guidance as to the additional material or information required to perfect the claim will also be given.

Notice of any decision denying the claim must be furnished within 90 days after the claim is filed. If special circumstances require an extension of time to act on the claim, another 90 days will be allowed. If such an extension is required, notification will be given by Anthem Health & Life Insurance Company of New York before the end of the initial 90 day period. If the claim is not processed or a notice is not given within these time periods, the claim will be deemed to have been denied for the purpose of proceeding to the claim review procedure described below.

APPEAL OF A CLAIM DENIAL

If there are any questions about a claim payment, Anthem Health of New York should be contacted. If it is desired to initiate a claim review procedure because there is a disagreement with the reasons why the claim was denied, Anthem Health of New York should be notified in writing within 60 days after receipt of the written claim denial. A request for a review of the claim and examination of any pertinent documents may be made by the claimant or anyone authorized to act on his or her behalf. The reasons why it is believed that the claim should not have been denied, as well as any data, questions or appropriate comments, should be submitted in writing.

The responsibility for full and final determinations of eligibility for benefits; interpretation of terms; determinations of claims; and appeals of claims denied in whole or in part under the Anthem Health of New York Group Policy rests exclusively with Anthem Health of New York.

DECISION OF REVIEW

Notification of the final decision will be given 60 days after receipt of a request of review unless special circumstances, such as a Peer Review Board review of the claim, require an extension of time for processing. In which event a further 60 days will be allowed. You will be notified of Anthem Health of New York's final decision no later than 120 days after receipt of the request for review.

CHANGE OR DISCONTINUANCE OF THE PLAN

We reserve the right at any time to change or discontinue all or any portion of the benefits described in this summary.

INDEX

HIPAA MODIFICATION

PLEASE KEEP THIS WITH THE CERTIFICATE OR BOOKLET OF GROUP COVERAGE

ANTHEM HEALTH & LIFE INSURANCE COMPANY OF NEW YORK certifies that the coverage described in the Plan and Certificate has been modified in order to comply with the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Modification changes the Plan and Certificate (in spite of anything to the contrary stated in the Plan/Certificate). These changes are effective on the later of the first renewal date of the Plan on or after July 1, 1997, or the date required by State or Federal law.

For the purposes of this HIPAA Modification, the terms large employer and small employer have the meanings as defined by the state, if any, in which this Modification is issued. In addition, unless mandated differently by state law, any additional provisions or limitations with respect to creditable coverage, pre-existing condition limitations, termination of coverage provisions, etc that are contained in the Plan, and which do not conflict with those stated here, still apply.

The HIPAA modifications are as follows:

DEFINITIONS

The following terms are added and replace previously defined terms by the same name, if any.

Creditable Coverage includes the following:

1. any group health coverage (including FEHBP - "Federal Employee Health Benefit Plan" & the Peace Corps) including any group continuation coverage such as COBRA;
2. any individual health coverage;
3. Parts A or Part B of Medicare;
4. Medicaid, other than the program for distribution of pediatric vaccines;
5. CHAMPUS - "Comprehensive Health Accident & Medical Plan for Uniform Services;
6. A medical care program of the Indian Health Service, or tribal organization coverage;
7. A state health benefits risk pool;
8. A public health plan as defined by Federal Regulation; or
9. any other arrangement sponsored by the state.

Enrollment Date means the date an eligible person first enrolls for coverage, or, if earlier, the first day of the Waiting Period for enrollment (typically the person's date of hire). When enrolling as a Late Enrollee, or during a Special Enrollment Period, the Enrollment Date means the first day of coverage under the Plan.

Full time- means doing the normal duties of your job at least 30 hours a week or more on a regular basis. Part-time, temporary, or substitute employees are not eligible.

Late Enrollee means an eligible person who applies for coverage under this Plan other than during the Initial Enrollment Period. A person will not be considered a "late enrollee" for medical expense coverage if eligible to enroll during a Special Enrollment Period.

Open Enrollment Period means a period of time (at least 30 days in duration but not less than that required by applicable law) which is held no less frequently than once in any 12 consecutive months/18 for HMO plans, during which Late Enrollees may be enrolled for coverage. If your Employer offers more than one plan, or if enrollment is for an HMO plan , the Open Enrollment Period also applies to all eligible persons who may enroll at that time as well. You may apply for coverage prior to an Open Enrollment Period, however if applying as a Late Enrollee, the Late Enrollee's medical coverage will not start until the first day of the month after the Open Enrollment Period ends.

Plan- for the purposes of this Modification only, means group health insurance policy, group contract, or group service agreement, or group plan of health benefits.

Planholder- for the purposes of this Modification only, means the Policyholder, Employer, or Group for which health benefits are being provided under this Plan.

Waiting Period- means a period of time that must pass before an employee or dependent is eligible to enroll for coverage under the Plan. If an employee or dependent enrolls as a Late Enrollee or on a Special Enrollment Date, any period before such late or special enrollment date is not a waiting period.

ELIGIBILITY

Employee Eligibility
You are eligible under this Plan if you are a full-time employee of an Employer.

You are eligible on the later of: (a) the date you become a full-time employee and satisfy any applicable waiting period; or (b) the Plan Effective Date. This is your eligibility date. Full- time employees who are absent from work due to a health related disability, maternity leave or regularly scheduled vacation on their eligibility date will still be eligible to enroll.

Dependent Eligibility
Your Dependents are eligible under this Plan on the date they meet the Dependent eligibility requirements described in your Certificate.

Initial Enrollment Period
You have 31 days after your eligibility date to apply for coverage for you and any eligible dependents. This is your Initial Enrollment Period. If you apply more than 30 days after your eligibility date, or 30 days after any date that your Dependents first become eligible, then you or your Dependent may be considered a Late Enrollee unless enrolling during a Special Enrollment Period.

Open Enrollment Period

If your employer offers more than one benefit plan, or offers an HMO plan, and you have been continuously covered under one of those plans, you may switch to coverage under this Plan and enroll for coverage for both you and your eligible Dependents during an Open Enrollment Period. In this case neither you or your Dependents will be considered a Late Enrollee and coverage will start on the first day of the month which falls after the end of the Open Enrollment Period.

Except for as stated above, if an Employee applies for medical coverage for the Employee and or their eligible Dependents at any time other than during an Initial Enrollment Period or a Special Enrollment Period, they will be considered a Late Enrollee. In this case medical coverage will start on the first day of the month which falls after the end of the Open Enrollment Period. In addition, any Pre-existing Condition limitation which may apply to a person under the Plan will apply from the date medical coverage starts under the Plan. The Pre-existing Condition limitation will be reduced by the length of time the person was excluded prior to the Open Enrollment Period; as well as by the time they were covered under any Creditable Coverage that was continuous to within 63 days of their effective date under the medical coverage.

Special Enrollment

An Employee or Dependent who was previously eligible for coverage under this Plan, and who declined coverage for themselves and their dependents during the Initial Enrollment Period, will be allowed to enroll during a Special Enrollment Period if they meet the following conditions:

1. The Employee or Dependent declined this coverage initially because they stated in writing at the time of enrollment that they had other coverage, AND the other coverage:
   a) terminated as a result of loss of eligibility for that coverage (due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment); OR
   b) was COBRA continuation which exhausted; OR
   c) terminated as a result of employer contributions towards such coverage ceasing; and
2. Enrollment must be no later than 30 days after the date such coverage above terminated.
3. Also, if an employee gains a Dependent through marriage, birth, or adoption, or placement for adoption, the employee may enroll themselves and their dependent under this Special Enrollment provision. They must apply no later than 30 days after the date the person is eligible for coverage.

When Coverage Becomes Effective

Coverage for an Employee or Dependent under this Plan takes effect beginning on or after the later of the following dates:

1. If enrolling **on or before the person's eligibility date**, or during the Initial Enrollment Period, coverage is effective on the first day of the month on or after the date the person is eligible to enroll; or
2. If a covered employee is enrolling a newborn or adopted child, coverage is effective on the date of birth or the date of adoption or placement for adoption; or
3. If a covered employee is enrolling a spouse in the case of marriage, coverage is effective on the first day of the first calendar month beginning after the date the completed request is received.
4. If enrolling during a Special Enrollment Period, coverage is effective on the first day of the month beginning after the date the completed request for enrollment is received by us; or
5. If enrolling during an Open Enrollment Period as a Late Enrollee or otherwise, coverage will not start until the first day of the month after the Open Enrollment Period ends.

Late Enrollment

An eligible Employee or Dependent who did not request enrollment for coverage during their Initial Enrollment Period or Special Enrollment Period may apply for coverage as a Late Enrollee.

The Late Enrollee will be subject to the Pre-Existing Condition limitation applicable to Late Enrollees as specified in the Pre-Existing Condition provision of this Modification.

Pre-Existing Condition Limitation (this provision may vary due to state law)

No benefits will be paid for expenses incurred with respect to a Pre-existing Condition until after a person has been covered under the Plan for 12 months in a row from the Enrollment Date.

A Pre-Existing Condition is a sickness, injury or related condition, **regardless of the cause of the condition**, for which medical advice, diagnosis, or treatment, was recommended by a physician or received within the 6 months immediately prior to the Enrollment Date. Pregnancy is not considered a Pre-Existing Condition. Genetic information may not be treated as a pre-existing condition in the absence of a diagnosis related to the condition.

The Pre-existing Condition exclusion does not apply to:

a. Pregnancy;

b. a newborn child, an adopted child, or child placed for adoption, if the child becomes insured under any Creditable Coverage within the first 30 days after birth, adoption or placement, and coverage was continuous to within 63 days of the child's effective date under this Coverage; or

c. genetic information, unless there is a diagnosis related to the information.

Pre-existing Condition Limitation for Late Enrollees
If an employee or dependent enrolls as a Late Enrollee, no benefits will be paid for expenses incurred with respect to a Pre-existing Condition until after a person has been covered under the Plan for 18 months in a row from the Enrollment Date.

Credit for Prior Creditable Coverage. Any Pre-existing Condition Limitation period will be reduced by any aggregate periods of prior Creditable Coverage applicable to the individual as of their Enrollment Date under this Plan. Prior coverage does not count as creditable if there was a break in coverage of more than 63 consecutive days or more prior to the Enrollment Date where the individual did not have any Creditable Coverage. Any waiting periods satisfied under any prior plans are not taken into account in determining this break in coverage.

If an employee or dependent enrolls as a Late Enrollee, or on a Special Enrollment Date, for the purposes of reducing the pre-existing condition limitation period, any period before such late or special enrollment date is not a waiting period and the pre-existing condition limitation period will not be reduced by any such period.

Termination of the Plan
This Plan is guaranteed renewable to all eligible employees and dependents at the option of the Planholder except as stated below.

Upon 30 days advance written notice we may terminate this Plan in its entirety as of the last day of any Plan month in the following circumstances:

1. Nonpayment of premiums by the Planholder, except as the Grace Period applies;
2. Fraud or misrepresentation of material fact by the Planholder;
3. Noncompliance with contribution or participation requirements;
4. For provider network Plans, when there is no longer any person under the Plan residing, living, or working within the state; or
5. For association group Plans, the group's membership in the association ceases;
6. We elect to non-renew all of our health benefit plans issued in the large employer market, the small employer market, or both, in this state. In such case, we will provide at least 180 days notification to the covered person, the Plan, and the state department of insurance, of our intent to non-renew. We will not offer group health coverage in the applicable market thereafter within the state for at least five years.
7. We elect to discontinue a particular product in the large employer market, the small employer market, or both, in this state. In such case, we will provide at least 90 days notification to the Plan, and the covered person, of our intent to discontinue the particular product. We will give the Planholder the option to obtain other types of health coverage currently being offered.

Benefits for all covered persons will terminate on the date of Plan termination, except for any applicable extension of benefits provision.

These changes are effective as of the effective date shown on this Modification. These changes may be subject to some state variations. All other provisions of the Plan and the Certificate remain unchanged.

IMPORTANT - THIS MODIFICATION SHOULD BE KEPT WITH THE GROUP PLAN AND/OR THE CERTIFICATE.

Customer Service: *1-866-766-9016*	**Pre-Certification:** *1-800-582-1535*
Provider Inquiry: *1-866-766-9016*	**Imaging:** *1-800-456-4647*
Pharmacy Help Line: *1-800-248-1062*	**Medical Testing:** *1-800-456-4647*
Billing Inquiries: *1-866-766-9016*	**Claims Inquiries:** *1-866-766-9016*

CLAIMS MAILING ADDRESS:
AFID LLC
1 S. Limestone Street Suite 301
Springfield, OH 45502

To Find a Network Provider
Go To: www.nhbc.com

Enter Access Code: 2000

Attn: Administration
718-370-6090
718-370-5386

Student verification for the following account:

7-6-07

AFID LLC Multiplan RESTAT

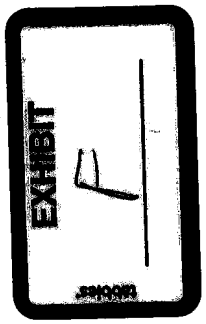
Insured Name:
Elizabeth Krajewski

Effective Date: 4/1/2007

PER4MANCE HEALTH PLAN
Coverage: Family
Group No: PH01
Member ID: 110009631
Pin No: 2000

PER4MANCE RX
Member ID No: 110009631
BIN No: 600471
Group: 2985
DOB: 1/30/44

EXHIBIT
E



Customer Service: *1-866-766-9016*	**Pre-Certification:** *1-800-582-1535*
Provider Inquiry: *1-866-766-9016*	**Imaging:** *1-800-456-4647*
Pharmacy Help Line: *1-800-248-1062*	**Medical Testing:** *1-800-456-4647*
Billing Inquiries: *1-866-766-9016*	**Claims Inquiries:** *1-866-766-9016*

CLAIMS MAILING ADDRESS:
AFID LLC
1 S. Limestone Street Suite 301
Springfield, OH 45502

To Find a Network Provider
Go To: www.nhbc.com

Enter Access Code: 2000

AFID LLC Multiplan RESTAT

Insured Name:
Edward Krajewski

Effective Date: 4/1/2007

PER4MANCE HEALTH PLAN
Coverage: Family
Group No: PH01
Member ID: 110009631
Pin No: 2000

PER4MANCE RX
Member ID No: 110009631
BIN No: 600471
Group: 2985
DOB: 6/8/44

HealthCare Strategies, Inc.
9841 Broken Land Parkway
Columbia, MD 21046

5/9/2007

RECOMMENDATION NOTIFICATION

Edward Krajewski
256 Kenilworth Avenue
Kenilworth, IL 60043

Patient Name	Edward Krajewski
Treating Physician:	Xiaoying Hensel, MD
Facility:	Evanston Hospital Corporation
Group/BE	PerfectHealth Insurance Co - Group Plan
Reference #:	369838
Requested to Service	Inpatient
Admit/Service Date	5/6/2007
Discharge Date	
Total Days Requested to date	6
Total Days Used to date	3
Total Services Requested to date	0

HealthCare Strategies, Inc. medical management team has completed a medical review for: Edward Krajewski. Based on the clinical information received, it has been determined that the service proposed is medically appropriate. Below is a summary of recommendations to date:

Date Recommended	# of Days Recommended	# of Days Non Recommended	Level of Care	Total Recommended
5/9/2007	6	0	Intensive Care Unit (Adult)	6
Decision Start Date	5/6/2007	Decision End Date	5/11/2007	

Date Recommended	Procedure	Range	# of Services Recommended	# of Services Non Recommended	Level of Care	Total Recommended
5/9/2007	33530		0	0	Surgical Confinement (Adult)	0

33530 - Coronary artery, bypass/reop

Ongoing treatment for this service will be reviewed periodically (concurrent review) in order to determine continued medical appropriateness. The next review date is 5/14/2007. If, during the concurrent review process, HealthCare Strategies, Inc.determines that the above service no longer meets medical requirements, you will be notified of the adverse determination in writing.

If this treatment is currently classified as experimental, investigational, and/or part of a clinical trial, as of 5/9/2007, then it may not be a covered benefit, and this recommendation notification is not valid for this service(s).

Please call HealthCare Strategies, Inc. at 1-800-582-1535 with any questions that you may have about this notification. HealthCare Strategies, Inc. nurses are also available to assist you with any healthcare related questions or concerns that you

Sincerely,

HealthCare Strategies, Inc.
CC: Xiaoying Hensel, MD

**** This notification represents a recommendation regarding the services requested only. The recommendation is not a guarantee nor denial of payment . For benefits, claim payment status and eligibility questions you must contact the claims payor; PerfectHealth Insurance Company (718) 370-5380.**

HealthCare Strategies, Inc.
9841 Broken Land Parkway
Columbia, MD 21046

5/14/2007

RECOMMENDATION NOTIFICATION

Edward Krajewski
256 Kenilworth Avenue
Kenilworth, IL 60043

Patient Name	Edward Krajewski
Treating Physician:	Xiaoying Hensel, MD
Facility:	Evanston Hospital Corporation
Group/BE	PerfectHealth Insurance Co - Group Plan
Reference #:	369838
Requested to Service	Inpatient
Admit/Service Date	5/6/2007
Discharge Date	
Total Days Requested to date	9
Total Days Used to date	8
Total Services Requested to date	3

HealthCare Strategies, Inc. medical management team has completed a medical review for: Edward Krajewski. Based on the clinical information received, it has been determined that the service proposed is medically appropriate. Below is a summary of recommendations to date:

Date Recommended	# of Days Recommended	# of Days Non Recommended	Level of Care	Total Recommended
5/9/2007	6	0	Intensive Care Unit (Adult)	6
Decision Start Date	5/6/2007	Decision End Date	5/11/2007	
5/14/2007	3	0	Intensive Care Unit (Adult)	9
Decision Start Date	5/12/2007	Decision End Date	5/14/2007	

Date Recommended	Procedure	Range	# of Services Recommended	# of Services Non Recommended	Level of Care	Total Recommended
5/9/2007	33512		1	0	Surgical Confinement (Adult)	1
5/9/2007	33530		0	0	Surgical Confinement (Adult)	0
5/9/2007	33973		1	0	Surgical Confinement (Adult)	1
5/9/2007	37.22		1	0	Surgical Confinement (Adult)	1

33512 - CABG, vein, three
33530 - Coronary artery, bypass/reop
33973 - Insert balloon device
37 22 - LEFT HEART CARDIAC CATHETERIZATION

EXHIBIT H

Ongoing treatment for this service will be reviewed periodically (concurrent review) in order to determine continued medical appropriateness. The next review date is 5/15/2007. If, during the concurrent review process, HealthCare Strategies,

**** This notification represents a recommendation regarding the services requested only. The recommendation is not a guarantee nor denial of payment. For benefits, claim payment status and eligibility questions you must contact the claims payor; PerfectHealth Insurance Company (718) 370-5380.**

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Sincerely,

HealthCare Strategies, Inc.
CC: Xiaoying Hensel, MD

**** This notification represents a recommendation regarding the services requested only. The recommendation is not a guarantee nor denial of payment . For benefits, claim payment status and eligibility questions you must contact the claims payor; PerfectHealth Insurance Company (718) 370-5380.**

PerfectHealth™
Insurance Company

June 29, 2007

Realty Benefits Associates, LLC
118 A Fulton Street
New York, NY 10038
Attn: Rena Kokinakos

Re: Group Plan #: 595246
Member: Edward Krajewski

Dear Rena:

On March 30, 2007 PerfectHealth advised RBA that non New York members will no longer be added to the Realty Benefits plan effective May 1, 2007.

We have reviewed the enrollment information submitted on behalf of the above named member and have determined that based on the data provided on the original enrollment card he is not eligible. It should be noted that the original enrollment card was altered to allow for an earlier effective date then our underwriting guidelines allow. We are in possession of both the original and the altered enrollment for which were both supplied by RBA. The un-altered enrollment application completed by this member, reflects a signature date of April 11, 2007 which would have resulted in a coverage effective date of May 1, 2007. However, as stated above, non New York members are not eligible for coverage beyond April 1, 2007.

In addition, a review of the enrollment forms indicates that the earnings qualifications needed based on the 2005 Schedule C submitted, did not meet our underwriting guidelines. Accordingly, this enrollee should not have been included in your group.

Please advise this member that his enrollment request has been denied and that all materials previously sent to you for this member should be discarded.

Should you have any questions please feel free to contact me.

Sincerely,

Antoinette Lapetina
Director HSA Services

AFID LLC
Association of Franchise & Independent Distributors

One South Limestone Street, Suite 301, Springfield, OH 45502
Phone: 1-866-766-9016 Fax: 937-398-5184

9/12/2007

EDWARD KRAJEWSKI
256 KENILWORTH AVE
KENNILWORTH, IL 60043-

Card I.D.:110009631

Dear Member;

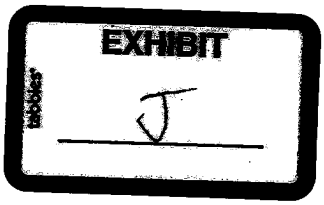
Per your request to cancel your Health Benefit plan, please find your refund check enclosed.

If we can be of any service to you in the future, please contact us.

Thank you.

Billing Department

Enclosure



AFID LLC
Association of Franchise & Independent Distributors

One South Limestone Street, Suite 301, Springfield, OH 45502
Phone: 1-866-766-9016 Fax: 937-398-5184

September 17, 2007

Mr. Edward Krajewski
256 Kenilworth Ave.
Kenilworth, IL 60043

Mr. Krajewski,

Based upon information received from Perfect Health Insurance Company received by way of Real Benefits Association, your coverage has been denied by the carrier. As a result, a return of premiums paid to date was processed on September 9, 2007 in the amount of $3320.28.

Please refer to the enclosed letter.

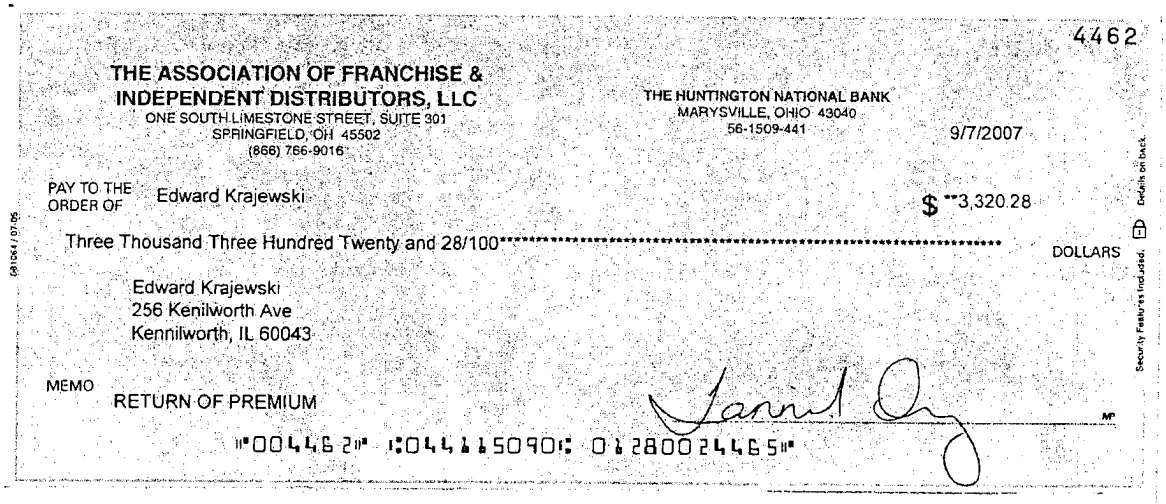
If you have any questions regarding this refund please contact us at 1-866-766-9016

Sincerely,

Kathy Sallot
Director of Billing Department

Enclosure

EXHIBIT
K



4462

THE ASSOCIATION OF FRANCHISE & INDEPENDENT DISTRIBUTORS, LLC
ONE SOUTH LIMESTONE STREET, SUITE 301
SPRINGFIELD, OH 45502
(866) 766-9016

THE HUNTINGTON NATIONAL BANK
MARYSVILLE, OHIO 43040
56-1509-441

9/7/2007

PAY TO THE ORDER OF Edward Krajewski

$ **3,320.28

Three Thousand Three Hundred Twenty and 28/100********** DOLLARS

Edward Krajewski
256 Kenilworth Ave
Kennilworth, IL 60043

MEMO RETURN OF PREMIUM

⑈004462⑈ ⑆044115090⑆ 01280024465⑈

Details on back. Security Features Included.

THE ASSOCIATION OF FRANCHISE & INDEPENDENT DISTRIBUTORS, LLC Edward Krajewski		9/7/2007	4462
	RETURN OF PREMIUM (APR, MAY, JUN, JUL)		3,320.28

Huntington	RETURN OF PREMIUM	3,320.28

THE ASSOCIATION OF FRANCHISE & INDEPENDENT DISTRIBUTORS, LLC Edward Krajewski		9/7/2007	4462
	RETURN OF PREMIUM (APR, MAY, JUN, JUL)		3,320.28

Huntington	RETURN OF PREMIUM	3,320.28

DELUXE BUSINESS FORMS 1-800-328-0304 www.deluxeforms.com